NOTE

This Microfiche meets the quality requirements of the American National Standard for Microfiche of Documents (ANSI PH5.9-1975). However, because of imperfections in the document from which it was made, it contains images that are illegible or difficult to read. The source document for this microfiche is the best copy that could be obtained prior to filming.

[illegible]

CIS

FEDERAL WORKERS' COMPENSATION FRAUD AND ABUSE, PART II

HEARING

BEFORE THE

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

OF THE

COMMITTEE ON GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

MARCH 31, 1982

Printed for the use of the Committee on Governmental Affairs

U.S. GOVERNMENT PRINTING OFFICE
94-425 O WASHINGTON : 1982

S401-45

COMMITTEE ON GOVERNMENTAL AFFAIRS

WILLIAM V. ROTH, Jr., Delaware, *Chairman*

CHARLES H. PERCY, Illinois
TED STEVENS, Alaska
CHARLES McC. MATHIAS, Jr., Maryland
JOHN C. DANFORTH, Missouri
WILLIAM S. COHEN, Maine
DAVID DURENBERGER, Minnesota
MACK MATTINGLY, Georgia
WARREN B. RUDMAN, New Hampshire

THOMAS F. EAGLETON, Missouri
HENRY M. JACKSON, Washington
LAWTON CHILES, Florida
SAM NUNN, Georgia
JOHN GLENN, Ohio
JIM SASSER, Tennessee
DAVID PRYOR, Arkansas
CARL LEVIN, Michigan

JOAN M. MCENTEE, *Staff Director*

PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

WILLIAM V. ROTH, Jr., Delaware, *Chairman*
WARREN B. RUDMAN, New Hampshire, *Vice Chairman*

CHARLES H. PERCY, Illinois
CHARLES McC. MATHIAS, Jr., Maryland
JOHN C. DANFORTH, Missouri
WILLIAM S. COHEN, Maine

SAM NUNN, Georgia
HENRY M. JACKSON, Washington
LAWTON CHILES, Florida
JOHN GLENN, Ohio
JIM SASSER, Tennessee

S. CASS WEILAND, *Chief Counsel*
MICHAEL C. EBERHARDT, *Deputy Chief Counsel*
ELEANORE J. HILL, *Chief Counsel to the Minority*
KATHERINE BIDDEN, *Chief Clerk*

CONTENTS

Testimony of:

Page

Berrington, Craig, Associate Deputy Under Secretary, Employment Standards Administration, U.S. Department of Labor 29

Collyer, Robert, Deputy Under Secretary, Employment Standards Administration, U.S. Department of Labor 29

Cox, Howard W., staff counsel, Permanent Subcommittee on Investigations 4

Hainer, Karen A., staff investigator, Permanent Subcommittee on Investigations 4

McBride, Thomas F., Inspector General, U.S. Department of Labor 19

Rogers, Lawrence, Director, Office of Program Development and Accountability, U.S. Department of Labor 29

EXHIBITS

1. Copy of chart showing DOL's broken promises to improve FECA 5
2. Article which appeared in Medical World News, dated March 15, 1982, concerning Dr. Richard K. Howell, accused of medicaid fraud 7
3. Copy of medical provider's claim form filed by Dr. Dent 10
4. Copy of letter to Mr. Richard V. Robilotti, workers' compensation adviser from John D. McLellan, Jr., Associate Director for Federal Employees' Compensation 15
5. Copy of letter to Mr. Richard V. Robilotti, workers' compensation adviser from William H. Ethe, Assistant Regional Commissioner, Internal Revenue Service 17

APPENDIX

Prepared statements:

Collyer, Robert B., Deputy Under Secretary, Employment Standards Administration, U.S. Department of Labor 74

Cox, Howard W., staff counsel, and Hainer, Karen A., staff investigator, Permanent Subcommittee on Investigations 43

McBride, Thomas F., Inspector General, U.S. Department of Labor 60

FEDERAL WORKERS' COMPENSATION FRAUD AND ABUSE, PART II

WEDNESDAY, MARCH 31, 1982

U.S. Senate,
Permanent Subcommittee on Investigations
of the Committee on Governmental Affairs,
Washington, D.C.

The subcommittee met at 10:05 a.m., pursuant to notice, in room 3302, Dirksen Senate Office Building, under authority of Senate Resolution 361, dated March 5, 1980, Hon. William V. Roth, Jr. (chairman of the subcommittee) presiding.

Member of the subcommittee present: Senator William V. Roth, Jr., Republican, Delaware.

Also present: Senator Don Nickles, Republican, Oklahoma.

Members of the professional staff present: S. Case Weiland, chief counsel; Michael C. Eberhardt, deputy chief counsel; Eleanore J. Hill, chief counsel to the minority; Katherine Bidden, chief clerk; Howard Cox, staff counsel; and Karen Hainer, investigator.

[Member present at convening of hearing: Senator Roth.]

[Letter of authority follows:]

U.S. Senate,
Committee on Governmental Affairs,
Senate Permanent Subcommittee on Investigations,
Washington, D.C.

Pursuant to Rule 5 of the Rules of Procedure of the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs, permission is hereby granted for the chairman, or any member of the subcommittee as designated by the chairman, to conduct open and/or executive hearings without a quorum of two members for the administration of oaths and taking testimony in connection with hearings on Fraud and Abuse in the Operation of the Federal Employees Compensation Act on Wednesday, March 31, 1982.

William V. Roth, Jr.,
Chairman.
Sam Nunn,
Ranking Minority Member.

Chairman Roth. The subcommittee will please be in order.

This morning the Senate Permanent Subcommittee on Investigations will continue its examination of fraud and abuse in the operation of the Federal Employees' Compensation Act. As you well know, the basic purpose of this important program is to provide benefits to Federal employees who have been hurt on the job. And our principal interest is to insure that such employees are fairly and compassionately compensated. But unfortunately, when we held the hearings last July, we did not like what we saw. We saw that the program was characterized by poor administration. Indeed, one could even call it lousy. It was characterized by fraud and abuse.

One of the things that especially concerned me was that it was predicted.

[At this point in the hearing, Senator Nickles entered the hearing room.]

Chairman ROTH. No wonder the predictions were so bad. All one had to do is look at some of the illustrations of poor management. For example, we found that medical providers were filing claims for compensation for seeing Federal employees who had not seen that doctor in literally years. Despite this record of fraud or abuse, the Department of Labor said it had no authority to prevent those medical providers from providing future services unless the medical society of his State had taken action against him.

I find that outrageous and unbelievable. But I guess the thing that has concerned me as I look at the record of performance, and we will go into detail on that at a later time, is that the history of those responsible for managing this program have come before congressional committees time and again, made promises that they were going to introduce new, innovative reforms and, yet, when you examine what happened 6 months or 6 years later, nothing occurred.

There appears to be no commitment to make this a well-managed program, and I can assure those who are in the Department of Labor today that this subcommittee will not be satisfied, until we see some internal controls put in effect that insures the American taxpayer that his or her dollar is being well spent. No longer are we going to permit the shoveling out of the money without any care as to whether the claims are legitimate or not.

So I just want to say to those in the Department of Labor who are responsible for this program that I am not satisfied with what I have learned. I was not satisfied in July, and I don't like what I am hearing today.

Quite frankly, if those responsible for the program cannot administer it, then it is time we get some who can. The Reagan administration has promised that it's going to reduce or eliminate waste, fraud, and abuse, and it is the special charge of this subcommittee to make sure that those promises are kept whether they are the Department of Defense or the Department of Labor.

So I just want to make it very clear that we will not be satisfied today if all we hear are future promises of reform.

We have with us today, and I am pleased to welcome, the Inspector General of the Department who will discuss with us his office's activity in identifying fraud and waste within the program. I believe Tom McBride is a good example of the kind of professionals we need in the ranks of our IG's.

We will also hear from subcommittee staff and, finally, from the head of the Employment Standards Administration, the office within the Department of Labor that is responsible for the management of the program.

First of all, I would like to welcome Senator Nickles for being with us today who has special responsibility. I am pleased to be working with him and delighted you can be here today. Would you like to make an opening statement?

OPENING STATEMENT OF SENATOR NICKLES

Senator Nickles. I would like to express my gratitude to you for these oversight hearings you are having, and I wish to let you know, and others that are interested, that certainly as chairman of the Labor Subcommittee, we are going to follow the hearings you are having today, plus some of the changes that we have talked about in the past. We are currently involved in making some changes in the law, and I think some positive changes under the Longshore Act, which is like the Federal Workers' Compensation Act, that, I am going to say, closely parallel some of the abuses we now see under the FECA. It is certainly our intention to monitor the hearings you have, to cooperate with you and your staff, to do everything we can possibly do to work with the Department of Labor. I am pleased to see Mr. McBride and Mr. Collyer today, because I think they are two outstanding people, but we have a lot of work to do. I think that really is what your hearings will point out today.

I just wish to commit to you our staff and our time and our efforts to do what we can to follow up on your hearings to, one, insure that the Labor Department can do everything they can possibly do administratively, but also I think there will have to be some statutory changes, and I will certainly pledge to do everything I can do, statutorily, to make some of the needed reforms that must really be made.

Chairman Roth. I appreciate those remarks, and I want to assure you that I will do everything I can to help you bring about the statutory changes that are necessary.

Senator Nickles. Thank you.

Chairman Roth. At this time, I would like to insert in the record a statement submitted by Senator Sam Nunn.

STATEMENT OF SENATOR SAM NUNN

Mr. Chairman, I am pleased to participate this morning in the continuing efforts of this subcommittee to insure the fair and efficient administration of the Federal Employees Compensation Act. The majority staff has done an admirable and thorough job in examining the fraudulent abuse which has, unfortunately, plagued the current FECA claim system.

I took part in the original hearings on this subject held before the subcommittee last July. The abuse and shortcomings in the system which were highlighted during those hearings were, to say the least, extremely disturbing. As a result of those hearings, I, along with Senator Roth and Senator Rudman and other Senators, cosponsored S. 1724 in a specific effort to eliminate the possibilities for fraudulent abuse which now exist under FECA laws and regulations. Moreover, I was hopeful that the Labor Department itself would move administratively to correct procedural loopholes in the process which were under its authority to control.

Unfortunately, I understand that we will today hear evidence of the Labor Department's failure to significantly improve its administration of the FECA claim process since last July. If that be the case, I am most anxious to hear the reasons and justification for that inaction on the part of the Labor Department.

If we are to eliminate fraudulent abuse in FECA as well as other areas of Government activity, the agencies involved must work with Congress in ferreting out the sources of the problem. I would hope that these hearings effectively register the continuing willingness of this subcommittee to make every effort to correct the proven errors of the past in the administration of FECA claims.

Chairman ROTH. At this time, I will call forward our two PSI members, Howard Cox and Karen Hainer. They have conducted the majority of our investigation, have done a very thorough and complete job. So, Howard and Karen, would you please come forward. I would point out that all witnesses before this subcommittee are required to be sworn in. So would you please stand and raise your right hand.

Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Ms. HAINER. I do.

Mr. COX. I do.

Chairman ROTH. Please be seated. You may proceed. It is my understanding that you will summarize your rather complete report, but, without objection, your full statement will be included in the record as if read.[1]

TESTIMONY OF HOWARD W. COX, STAFF COUNSEL; AND KAREN A. HAINER, STAFF INVESTIGATOR, PERMANENT SUBCOMMITTEE ON INVESTIGATIONS

Ms. HAINER. Thank you, Mr. Chairman. Since the last hearing in July, we have spent the past 8 months reviewing the Department of Labor's Federal workers' compensation program. We have been out to some new district offices in Boston where we spent 2 weeks reviewing over 300 claims files. We have been to Philadelphia and Dallas, and we have been in the two offices here in Washington.

In the past month, we have contacted by phone every district office as well. We have spoken with claimants who have filed claims under this program, and we have also met with some of the agency officials from the various Federal employing agencies.

Today what we are going to report to you is that while some progress has been made in this program, more must be done to make good on the Labor Department's continued recitations that they are making reforms in this program.

At this time, with your permission, sir, I would like to introduce the first exhibit for the record. This is the same chart which appears to my right over here. This chart indicates a series of significant promises which the Department has continually made over the years to various congressional committees and to their own Inspector General. Most of the recommendations come from congressional studies or from their own internal studies which have critiqued problems within the Department. We will talk about that chart in more detail a little bit later on.

[The document referred to was marked "Exhibit No. 1," for reference and follows:]

---

[1] See p. 43 for the prepared statement of Howard W. Cox, staff counsel, and Karen A. Hainer, staff investigator.

EXHIBIT NO. 1

DOL'S BROKEN PROMISES TO IMPROVE FECA

PROMISE	WHEN & WHERE PROMISE MADE
1. OWCP has recruited and will utilize a medical staff at the central office to develope & coordinate FECA medical claims policy. ORIGINAL TARGET DATE: FY 79	a. 2/78 - House App. Comm. b. 5/80 - House Ed & Labor Comm. c. 5/81 - House Ed & Labor Comm. d. 7/81 - PSI
2. OWCP will obtain & use fee schedules. ORIGINAL TARGET DATE: 1/81	a. 10/80 - DOL OIG b. 7/81 - PSI
3. OWCP will develope reports to identify questionable medical service providers. ORIGINAL TARGET DATE: 10/81	a. 7/81 PSI
4. OWCP has developed and utilizes a lower back project to review claims from USPS & GPO in New York, San Francisco and D.C. ORIGINAL TARGET DATE: 1980	a. 5/81 - House Ed & Labor Comm. b. 7/81 - PSI
5. OWPC will develope & utilize a sophisticated computer system for claims. ORIGINAL TARGET DATE: FY 79	a. 2/78 - House App. Comm. b. 7/81 - PSI
6. OWCP will develope & utilize a form to verify the provision of medical services. ORIGINAL TARGET DATE: 12/81	a. 7/81 - PSI
7. OWCP will develope a training course for bill paying clerks ORIGINAL TARGET DATE: 10/81	a. 7/81 - PSI

Ms. Hainer. Right now, what I would like to do is bring you up to date on what has transpired in the past 8 months concerning an issue that came out of our last hearing.

At the last hearing, it was demonstrated that if a doctor who participates in the program is convicted of actually defrauding this Government program, the Labor Department can do nothing, in its opinion, to exclude or debar that doctor from further participation in the program.

At the time of the last hearing, Labor Department officials testified that no formal suspension or debarment mechanism had ever been proposed to the Secretary of Labor. They further speculated that they did not believe that authority to create such a mechanism existed under current laws or regulation.

In an effort to clarify this testimony, Mr. Chairman, you wrote to the Secretary of Labor in August and asked for additional information. The Secretary wrote back and said that he, too, did not believe that the authority existed to debar or exclude fradulent medical providers, but that his office would continue to study this issue.

Seven months went by. We did not hear any further word from the Department of Labor. You wrote again in March, and last Friday you received a response from the Secretary who now concedes that there is authority under current laws and regulations to debar or exclude medical providers who are convicted of some sort of medical fraud. The Secretary notes, however, that he would prefer some sort of legislation which specifically addresses this issue.

It is interesting to us that in the 7 months the Department was researching this area of debarment and suspension, the Department of Health and Human Services has continued to exclude medical providers from medicare or medicaid who have been found to be abusers in that program. This is an administrative procedure that we talked about at our last hearing, and we have continued to monitor how that procedure is working. What we have come across is not only that it works, but that the Department of Health and Human Services feels very comfortable in continuing to explore the possibility that an administrative debarment mechanism does not require the same legal standards of criminality needed to convict a doctor of a felony.

We have as exhibit 2 an instance we came across involving a doctor who was found not guilty by a jury of medicare-medicaid fraud. He was nonetheless barred from the medicare programs because the Department found that his billing procedures were sufficiently improper to warrant his exclusion.

[The document referred to was marked "Exhibit No. 2," for reference and follows:]

EXHIBIT NO. 2

MEDICAL WORLD NEWS
March 15, 1982

Cleared by jury, DO is cut by Medicare

PORTLAND, ORE.—"Not guilty" does not always mean "innocent." That's the message from HHS to osteopathic physician Richard K. Howell of this city.

Dr. Howell stood trial in federal court here in July 1980 on 103 counts of Medicare and Medicaid fraud, charged with, among other things, seeking payment for treating six patients who were dead. Assistant U.S. Attorney Jack Collins said the defendant had filed false claims for 193 visits to 44 nursing-home residents between April 1976 and February 1978.

The DO admitted billing errors but blamed them on the inexperience of his office staff. The jury accepted his denial of intentional fraud, clearing him on all counts.

But HHS wasn't through. The Seattle office of its Division of Quality Control recommended Dr. Howell's banishment from the Medicare program, arguing that his billing procedures may not have been found criminal but were sufficiently irregular to warrant action.

Apprised of his impending suspension, the doctor and his lawyer attended "an informational hearing" at HHS central offices in Baltimore last June. "We went to answer any questions they had," says Dr. Howell, "but they didn't ask any. We thought the trial record said it all."

Not quite. Ralph A. Howard, director of the agency's Bureau of Quality Control in Baltimore, recently informed Dr. Howell that he would be excluded from Medicare reimbursement for five years. "The same day, official notices were published in the local newspapers," the physician says. The notification document from HHS states that the not-guilty verdict "does not preclude the Secretary from imposing administrative sanctions be-

The fraud-trial verdict looked like a clean bill of health for Dr. Howell, but HHS is denying him reimbursement anyway.

MEDICARE continued

cause of the difference in the degree of proof in criminal and civil cases." The issue here, it went on, is whether the doctor "knowingly and willfully made or caused to be made false statements or misrepresentations of material facts." It concludes that he did.

The Medicare exclusion automatically denies Dr. Howell the feds' 50% of Medicaid reimbursements as well. "The state can still pay its share," comments John Diase, assistant regional administrator of the HHS quality-oversight branch in Seattle. "It may give nothing or pay the federal share, too." But Cliff Greenlick of the Oregon Adult and Family Services Division says state Medicaid claims from Dr. Howell will be refused so long as the HHS edict remains in effect.

The DO can contest the order, Diase notes—first before an administrative-law judge, then at the appeals council of the Social Security Administration, finally via a civil suit against the government. Dr. Howell plans to follow this course but concedes "it could take years." The 35-year-old practitioner adds that he continues to see his elderly patients. "They need care," he says, "but they can't afford to pay, so I'm providing services without charge." He expects his legal fees eventually to top $16,000—nearly three times the sum of the Medicare bills disputed by HHS.

The Oregon Osteopathic Association believes Dr. Howell has gotten a raw deal. "They [the feds] don't agree with the jury's findings," says OOA president J. Terry Dierdorff. "Therefore, they are rejecting them. Nowhere in the American system of jurisprudence is there a provision for bureaucrats to overturn or ignore a jury verdict.

"When the day comes that they can continue proceedings against an individual who has already been declared innocent, then this will indeed cease to be the 'land of the free,'" thundered Dr. Dierdorff.

Ward Wilson of the HHS quality-control office in Seattle says five "providers" (not all of them physicians) were drummed out of the Medicare program nationally last year for "false claims." Exclusions for all reasons came to 16. ■

Ms. Hainer. However, what we have found in the Department of Labor over the past 7 months is that its opinion has prevailed that only doctors who lose their medical licenses will be excluded from this program. Because of that position, we decided to take a look at the track record of medical societies and their actions to revoke or suspend physicians' licenses when they have been convicted of a criminal offense.

We picked the cases of the three doctors we referred to at our last hearing—Dr. Josephs, Dr. Kones, and Dr. Dent—and we went back and tried to see what had happened to these individuals.

In the case of Dr. Josephs, he was in a Federal penitentiary at the time of our last hearing. He had been convicted of insurance-related mail fraud. He was released in January of this year. The New York State Board of Medical Licensing did hold a hearing on revocation of Dr. Josephs' license, but their decision has not been made public at this time.

Additionally, the New York State Workers' Compensation Board revoked Dr. Josephs' authority to practice State workers' compensation. The Department of Labor, however, has taken no formal action against Dr. Josephs. This is in view of all of the information we presented at our last hearing.

If Dr. Josephs does not lose his license in New York State, he will be eligible to continue participating in FECA.

Dr. Kones was another doctor we talked about at our last hearing. He is a New York physician who, right after our hearing, pled guilty to over 60 counts of FECA and mail fraud. He was convicted and sentenced to serve 7 years and to repay $300,000 to the Government. He also agreed to repay half a million dollars to the Government to settle a civil fraud suit, and as a corollary to his plea agreement, he agreed to voluntarily resign his licenses in all the States in which he held licenses.

We went back and checked. We found that in five of the States in which he was licensed, he did give up his license and the States have noted the criminal conviction record in his file. In one State his license was removed without any prejudice, which means he can reapply for a license after a certain period of time. In another State, his authority to practice, his registration, fell by the wayside because he did not keep up his fee, but his license was not removed. In two other States, no action has been taken to remove his license.

Dr. Kones is a good example because he was convicted of perhaps the largest FECA fraud in the history of the program, at least to date, and he was given a relatively stiff sentence by the courts, yet the Department has taken no action to formally bar him from FECA. The only reason that he even lost his licenses in those States in which he did was because one prosecuting attorney made it a point to inform each State that Dr. Kones had been convicted and agreed to give up his medical license. But, normally there is no formal notification system between the Justice Department and State licensing boards to inform these boards when a doctor in their State is convicted of a criminal offense.

We spoke with a number of medical licensing boards, and they informed us that they rely on newspaper articles to find out about doctors who are convicted of abusive practices. Afterward, they must begin implementing their own administrative procedures to consider revocation of the doctor's license.

This is well illustrated in the case of Dr. Dent. There the system did not work very well. Those who had the responsibility to consider revocation of his license were not as serious in the delegation of their responsibilities. Dr. Dent was convicted in the district court here in Washington, D.C., of FECA fraud in June 1981. At the time of his sentencing, the court did have the power to revoke his license under D.C. law, but that was not done. No recommendation was made to do so, not even a recommendation to suspend his license. Rather, Dr. Dent went out and continued practicing.

We spoke with the medical licensing authorities, and we were informed in July that no recommendation had been made to the courts because they were unaware of Dr. Dent's conviction. We went back and spoke with them in February of this year, and the same individuals to whom we spoke informed us in February that they have never heard of Dr. Dent or his conviction. They told us that based on the information they had learned from us in February, they would begin some sort of action against Dr. Dent. We have heard no further of any action.

Dr. Dent, 2 months after his sentencing, was practicing medicine, and we have an example that he submitted bills to the Federal Workers' Compensation Program for treatment rendered to one Federal worker. Dr. Dent was paid promptly because the OWCP district director told us the law says all bills have to be paid.

This example is ironic because our review of this particular case file indicates that, irrespective of Dr. Dent's prior conviction record, the Department of Labor did not have to pay his bill. There is one administrative action that they acknowledge they can hold over a doctor and a claimant, and that is when a claimant switches from one doctor to another, or shops around, without prior OWCP approval. The claimant in this case had switched to Dr. Dent without prior approval. They could have denied the bill on that basis, but instead it remained an administrative oversight.

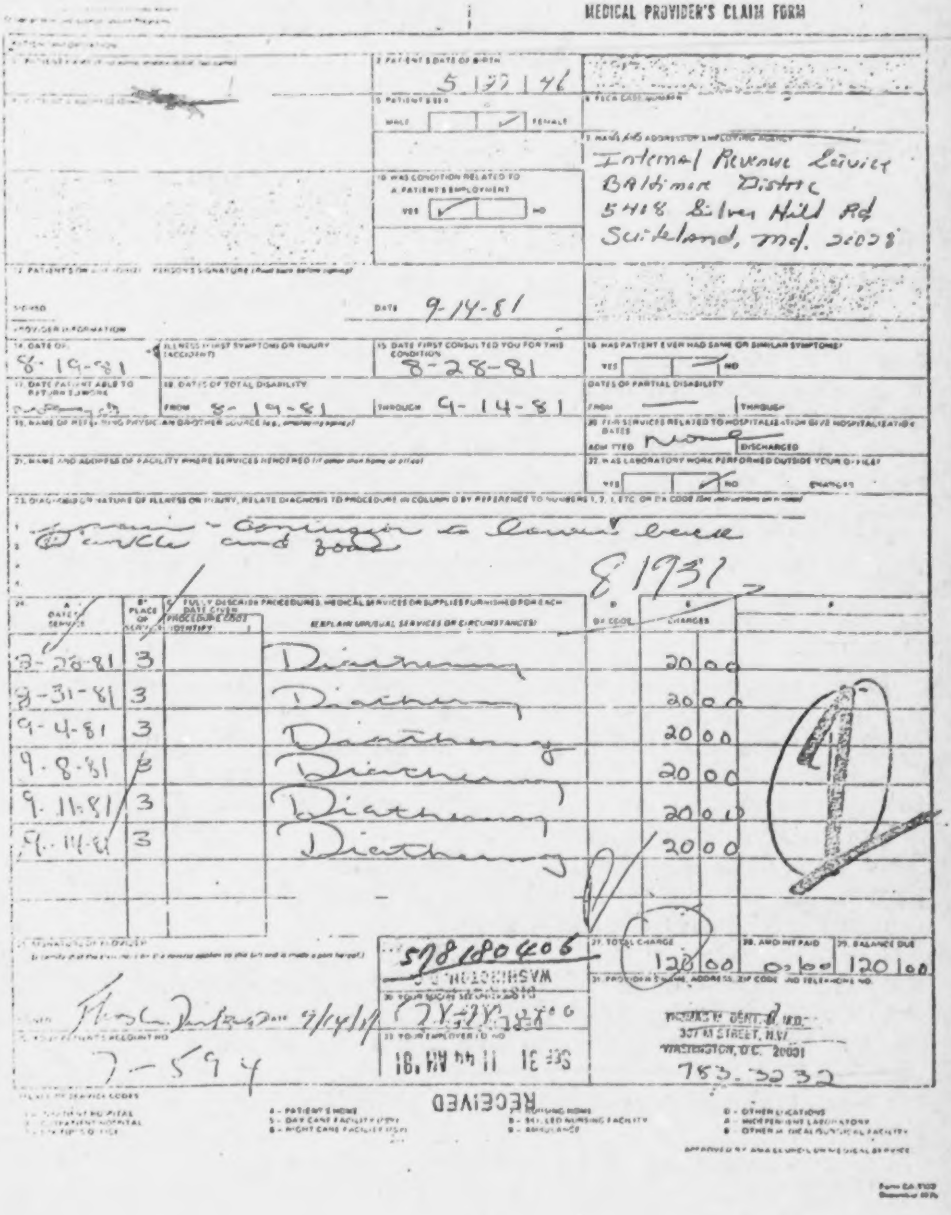
The information that we obtained on this particular case indicates that a reliance on medical societies to police the medical profession is inadequate. The Department of Labor cannot expect and, in fact, these medical societies are not doing an adequate job to protect the Government's interest.

I would like to introduce the example of Dr. Dent's bill as exhibit No. 3.

Chairman Roth. Without objection.

[The document referred to was marked "Exhibit No. 3," for reference and follows:]

EXHIBIT NO. 3



MEDICAL PROVIDER'S CLAIM FORM

PATIENT INFORMATION

1. Patient's name: [redacted]

2. Patient's date of birth: 5 | 27 | 46

5. Patient's sex: Male ☐ Female ☑

7. Name and address of employing agency:
Internal Revenue Service
Baltimore District
5418 Silver Hill Rd
Suitland, Md. 20028

10. Was condition related to patient's employment: Yes ☑ No ☐

12. Patient's or authorized person's signature — Signed / Date 9-14-81

PROVIDER INFORMATION

14. Date of illness (first symptom) or injury (accident): 8-19-81

15. Date first consulted you for this condition: 8-28-81

16. Has patient ever had same or similar symptoms? Yes ☐ No ☑

17. Date patient able to return to work: [illegible]

18. Dates of total disability: From 8-19-81 Through 9-14-81

Dates of partial disability: From — Through

20. For services related to hospitalization give hospitalization dates: Admitted None Discharged

22. Was laboratory work performed outside your office? Yes ☐ No ☑ Charges

23. Diagnosis or nature of illness or injury:
1. [illegible] - contusion to lower back
2. [illegible] ankle and [illegible]

8 1931

A. Date of service	B. Place of service	C. Procedure code	Fully describe procedures, medical services or supplies furnished for each date given	D. Dx code	E. Charges
8-28-81	3		Diathermy		20.00
8-31-81	3		Diathermy		20.00
9-4-81	3		Diathermy		20.00
9-8-81	3		Diathermy		20.00
9-11-81	3		Diathermy		20.00
9-14-81	3		Diathermy		20.00

25. Signature of provider — Date 9/14/81

578180406

26. Your patient's account no.: 7-594

27. Total charge: 120.00

28. Amount paid: 0.00

29. Balance due: 120.00

31. Provider's name, address, zip code and telephone no.:
THOMAS V. GENT, M.D.
337 M STREET, N.W.
WASHINGTON, D.C. 20031
783-3232

Place of service codes
1 - Inpatient hospital
2 - Outpatient hospital
3 - Doctor's office
4 - Patient's home
5 - Day care facility (PSY)
6 - Night care facility (PSY)
7 - Nursing home
8 - Skilled nursing facility
9 - Ambulance
0 - Other locations
A - Independent laboratory
B - Other medical/surgical facility

Approved by AMA Council on Medical Service

Form CA-1500

Ms. HAINER. We also came across two other examples that we believe illustrate the need for a suspension/debarment mechanism within the Department. We took a look at some of the medical services provided to a large New England postal facility. What we found there was that most of the workers injured on the job received medical treatment from one of two physicians who between them treated the largest number of Federal workers in that area.

One of the doctors had been a Postal Service physician. He was employed on a part-time basis in 1976 to work for the Postal Service. He was employed by the Postal Service for 4 years, and he treated hundreds of workers during that period of time. We found that in many of the instances in which he was the treating doctor, the postal workers elected this physician as their private treating physician. This is permissible under DOL regulations. They can use the Government doctor, or they can choose a doctor of their own choice. These workers told us they chose this doctor in his capacity as a Government doctor to treat them at the Postal Service facility.

The doctor would then execute the necessary Department of Labor form as the authorized Postal Service employee in such a manner so that he would award a contract to himself to provide private services at Government expense. Some of these services were provided at Government expense on Government property when it would be indicated on the forms that these services would be provided at his private office. Other services were actually provided at his private office.

We bring this to your attention because we have spoken with officials at the Tennessee Valley Authority, the Defense Department and the Veterans' Administration, all of which have in-house paid medical staff. We have some concerns that the same situation which occurred in the Postal Service may be taking place in these other agencies.

None of the personnel regulations of the Postal Service address this conflict of interest. The Department of Labor officials who processed these forms never noticed that the individual who signed their forms as the authorizing official and, the private treating physician were one and the same individual.

At the beginning of this description I mentioned two doctors. The other doctor in this community who treats a large number of workers injured on the job was indicted in 1980 for distributing cocaine. He has not yet been tried nor have the State medical licensing authorities taken any action against his license.

Mr. Cox. I would, sir, at this time like to draw your attention to the chart on my right which is exhibit 1. In our prepared statement, we have a full list of evidence which we feel demonstrates the Department of Labor's record in carrying out these various promises. Right now, I would like to summarize one or two of these promises to give you an understanding as to what the Department of Labor has done to carry out promises they have made to congressional committees both in the Senate and House, and to their own Inspector General.

One of the main points made at our last hearing is that the Department of Labor must execute better medical cost containment procedures. The Department of Labor currently estimates medical costs in this program will rise 15 to 20 percent annually, far in excess of our current inflation rate.

Last year in this program, medical costs accounted for over $110 million. Under the act, it is only required that the Government should have to pay for reasonable medical costs and it has been repeatedly urged to the Department of Labor in the last 6 years, by congressional committees, the Inspector General and internal management studies, that the Department of Labor should use fee schedules in order to help determine what are reasonable costs in a particular geographic area.

The choices available to the Department of Labor would be to develop their own fee schedules specifically tailored to the needs of FECA or adopt an existing fee schedule which may exist in medicare, medicaid, private insurance companies or State workers' compensation programs.

The Department of Labor has repeatedly stated they do use and will continue to use fee schedules. In response to an October 1980 memorandum of the Office of Inspector General, the Department of Labor specifically promised they would obtain and provide fee schedules to all district offices.

In response to the observations of this subcommittee last July, the Department of Labor indicated to us that all districts do, indeed, have and utilize fee schedules in order to determine reasonable costs.

Our subsequent survey of every district office in the last 8 months has concluded that of the 16 district offices in the Department of Labor, 13 offices never had and never have utilized fee schedules in any form. The remaining three district offices that do have a fee schedule physically located on the premises only utilize that schedule on a very limited basis.

The danger that arises from this lack of attention to medical cost containment is also reflected in the statement made to us by virtually every district director. Each of them stated to us that rarely, if ever, does the Department of Labor refuse to pay a bill based upon unreasonable costs. Every bill is virtually paid without a question.

A second point which has been consistently stressed upon the Department of Labor is that, on the national office level, there is a desperate need for competent, full-time medical advice; that a medical staff must be employed at the national level to provide guidance as to the administration of the medical aspects of FECA nationwide and to provide research on complicated medical issues, relating to workmen's compensation, such as stress, radiation, asbestos, and other work-related illness.

In response to repeated criticism in this area, the Department of Labor did, indeed, hire two physicians to serve as medical staff in 1980. The Department of Labor indicated to us last July that this office was taking great strides in implementing the medical guidance and providing the direction that has been recommended. Subsequently, however, we found out that just 2 weeks before our July hearing, both medical staff members quit and have not been replaced. So at the time the Department of Labor glowingly reported to us last July that the office was operating in a competent manner, they had no professional staff in that office.

We interviewed the former Director of the Division of Medical Services and Standards. She told us that during the tenure of her employment, her position was little more than window dressing and at no time did Department of Labor program officials in the Office of Workers' Compensation Programs make a deliberate commitment to carry out the recommendations she had made.

She also was never given a chance to coordinate with the district medical directors out in the field. Therefore, she felt her position was useless.

When we found out about this, we contacted the Department of Labor in November of last year. We were informed at that time that the positions had been reannounced and that a panel was screening applicants. We again contacted the Department of Labor in February 1982, and we were told both positions had not been and would not be filed because funding for the positions had been eliminated.

Based upon our reminding the Department of Labor as to the insistent concerns that have been expressed by congressional committees over the need for these positions, we were told that, as of the day after our meeting, the positions had been reannounced and that candidates are currently being sought.

I would like to point out that in 1978, the House Education and Labor Committee issued a report which stated they detected no sense of urgency on the part of the Department of Labor to staff these positions. It can be suggested that same lack of urgency is present in their current actions.

Another example of a promise which was not met in the way the Department of Labor represented is their lower back project. This project has been repeatedly offered as being the premier effort in controlling improper low back injury claims in the Department of Labor.

Lower back injuries are the most common kind of workmen's compensation injury. The Department of Labor developed an innovative program that would have every Federal employee who has a low back injury referred to an outside physician. This would then serve as an additional form of independent medical evidence for the Department of Labor and would also serve as a deterrent on frivolous or ficticious claims.

[At this point, Senator Nickles withdrew from the hearing room.]

Mr. Cox. In May 1981, Department of Labor officials testified before the House Education and Labor Committee. They stated that the program was in effect in three district offices—in the District of Columbia, in San Francisco, in New York. They said it applied to postal employees and employees of the Government Printing Office, and they specifically stated that as a result of that program, claims from those agencies for low back injuries had dropped by 50 percent.

Similar representations were made to this subcommittee last July. Our check revealed the actual status of the lower back project was much different than that represented to us and the House by the Department of Labor. First, we found that the project began in the District of Columbia office in 1980. However, after only referring six cases to outside physicians, the program in that district office collapsed in October 1980 and was not reestablished until January 1982.

Second, we found that the program had never even begun in the San Francisco office until June 1981, actually 1 month after they represented to the House that such a program was in effect in San Francisco.

Third, we found that the program has never been in operation in the New York District Office.

Fourth, we found that the program has never involved Government Printing Office employees.

Therefore, we should observe that despite the representations made to both this subcommittee and the House of Representatives as to the scope and effectiveness of this program, the actual operation of the program has been much less than that which was represented by the Department of Labor.

Another point that is made on this chart is that the Department of Labor has been repeatedly urged to develop internal program procedures to identify questionable medical providers. A questionable provider can be a provider engaged in criminal conduct or who is engaged in abusive practices, such as overbilling or billing for repetitive or unnecessary treatments.

In response to the concern voiced by this subcommittee last July, the Department of Labor promised to have a computer system in effect by October 1981 that would identify such abusive providers. The Department of Labor also specifically promised that they would issue guidance and guidelines to claims examiners in all district offices to help them identify and eliminate abusive providers. These guidelines were to be in effect by October 1981.

Our subsequent survey indicates that no such guidelines have ever been distributed to the district offices.

We also pointed out that various law enforcement and program agencies throughout the Federal Government engage in the identification of abusive providers. The Postal Service, the Inspectors General, the Health Care Finance Administration, all engage in such identification. However, there had been no evidence of the national office cooperating to obtain this information.

As proof of this point, we would like to show that the only initiative in this area has come from the district office level. Last July, we demonstrated that the New York Office was perhaps particularly susceptible to abusive providers. Following our hearings, the New York District Office did, indeed, try to obtain information on such providers. They wrote to the national office and requested their assistance in obtaining a listing of abusive providers.

At this time, I would like to introduce as an exhibit, Exhibit No. 4, which is the response by the national office to the New York District Office.

[The document referred to was marked "Exhibit No. 4," for reference and follows:]

EXHIBIT No. 4

U.S. Department of Labor

Employment Standards Administration
Office of Workers' Compensation Programs
Washington, D.C. 20210

File Number:

OCT 8 1981

OCT - 5 1981

MEMORANDUM FOR: RICHARD V. ROBILOTTI
Workers' Compensation Advisor
New York Regional Office

FROM: JOHN D. McLELLAN JR.
Associate Director for
Federal Employees' Compensation

SUBJECT: Senate Permanent Sub-Committee Hearings

This is in response to your memorandum dated August 24, 1981, same subject.

In your efforts to secure lists of medical providers who have been convicted of Medicare and/or Medicaid fraud, you should contact the regional office of the Department of Health and Human Services for assistance. Additionally, Medicare contractors in each state are required by law to make certain information available to the public. Therefore, you should also be able to obtain certain information from state government sources on Medicare providers.

We appreciate your continuing efforts to secure information that will help to discourage fraud and abuse in the Federal Employees' Compensation Program. If I can be of further assistance, please advise.

cc: White
Markey
Landis
Cato
Brown
Elbert
Bouker
Mercurio (NY RA)

Mr. Cox. In summary, the national office responded, "Thank you for your interest. Get it yourself."

Additionally, the Department of Labor has been hindered in identifying abusive providers by the inadequacy of their current computer system. In our last hearing, we went into substantial detail as to how the system is currently set up. Basically in order to identify a physician, they must have his IRS issued employer identification number. Without this number, the doctor cannot be identified within the system.

The Department of Labor told us in July that they were making contact with the IRS to develop information whereby they could validate and obtain EIN numbers once they had a physician's name. However, it is the insistent position of the IRS this is confidential taxpayer information and cannot be released to the Department of Labor.

As proof of this, we would like to place in the record Exhibit 5 which is a letter from the Internal Revenue Service, again, to the New York District Office saying they could not share the EIN number with them. The result of this is adequately demonstrated by the frustration of the New York District Office.

After our last hearing, they went to the State of New Jersey and obtained from the State of New Jersey a listing of those physicians who had lost their licenses in the State of New Jersey because of criminal or abusive acts. However, that listing of physicians did not have EIN numbers because the EIN numbers are of no use to New Jersey State licensing officials.

[The letter referred to was marked "Exhibit No. 5," for reference and follows:]

EXHIBIT NO. 5

Internal Revenue Service Department of the Treasury

Assistant
Regional
Commissioner

North-Atlantic Region

90 Church St., New York, N.Y. 10007

Mr. Richard V. Robilotti
Workers' Compensation Advisor
U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
1515 Broadway at West 44th Street (Room 3348)
New York, N.Y. 10036

Dear Mr. ~~Robilotti~~ Dick:

Reference is made to your letter of July 2, 1981. The employee identification numbers you requested are considered income tax return information. Internal Revenue Code 6103(a)(2) considers this data confidential and cannot be disclosed under the circumstances described in your request.

However, there is a procedure under Internal Revenue Code 6103(i)(2) for obtaining return information for use in a non-tax criminal proceeding pertaining to the enforcement of a specifically designated Federal criminal statute. The request is made by the head of the Federal Agency or by the Justice Department to the District Director with which the taxpayer filed his return. The critical element needed to obtain the information under 6103(i)(2) is a Federal criminal violation. A civil violation of the law is not sufficient.

I hope this information will be of assistance to you. If you need any additional information, please contact our Disclosure Officer, Mr. Lloyd Easlick, on 264-7722.

Sincerely yours,

William H. Ethe
William H. Ethe
Assistant Regional Commissioner
(Resources Management)

Mr. Cox. Upon being provided with this list, the Department of Labor was unable to identify any of these physicians because they were unable to get the EIN numbers.

As long as the Department of Labor insists on using the EIN as the sole identification characteristic of medical providers, it is unlikely they will be able to identify abusive providers.

In conclusion, we would like to observe that the Department of Labor has repeatedly promised Congress and their own Office of Inspector General that certain improvements will be made in the system by certain given deadlines, as indicated on Exhibit 1. Upon subsequent examination by the subcommittee of these 6 years worth of promises, it is respectfully submitted there has been little meaningful progress in the fullfillment of any of them.

Chairman Roth. If I understand the thrust of your testimony, it is that your investigation of developments since our hearings 8 months ago show no real significant improvement in the administration of this program; is that correct?

Mr. Cox. That is correct, sir.

Chairman Roth. Do you agree with that?

Ms. Hainer. Yes.

Chairman Roth. One of the things I think characterizes that this problem is in your testimony you stated that all of the district offices responsible for the administering of the program candidly admitted that no fee schedules or procedural instructions had ever been received from the national office. Almost all of the district office could not recall a single instance when a medical bill was refused for being too high or unwarranted. I find that almost unbelievable. Does that show any kind of internal control or administration?

Mr. Cox. Sir, without some sort of objective standard upon which the Department of Labor official could state that a bill is unreasonable, it is basically left up to the individual claims examiner, bill-paying clerks.

Despite repeated recommendations to use fee schedules, there has been no meaningful commitment by the national office to achieve this goal.

Chairman Roth. Karen, in your testimony you mentioned, I think in the Postal Service that a doctor who was a Government doctor was also providing medical services as a private practioner so that there was a conflict of interest.

Ms. Hainer. It was a conflict of interest and double billing because he was being paid as an employee to provide these services and he was billing the Department of Labor on top of that for the service.

Chairman Roth. You did make some mention of other agencies. What action did the Department of Labor take with respect to other agencies on this kind of a problem?

Ms. Hainer. I should say that this particular case was brought to our attention by the district office of the Department of Labor in Boston. The district people there know about the doctor and his case. He continues to treat workers——

Chairman Roth. I am not asking about him specifically.

Ms. Hainer. They feel there is nothing they can do about it. We went out and talked with TVA and DOD about the fact that they do have in-house medical staff. There is a possibility the same situation could arise, and they have no specific regulations to address this, nor has the Department of Labor promulgated any regulations to address this type of conflict of interest.

Chairman ROTH. In other words, despite the shocking nature of the Postal Service, no followthrough instructions, regulations or guidelines came out, to your knowledge, from the Department of Labor?

Ms. HAINER. Correct.

Chairman ROTH. Did you raise that question with them?

Ms. HAINER. Yes, we did.

Chairman ROTH. Time is moving on. I thank you both for your testimony.

At this time, I would like to call on Mr. Thomas McBride, the Inspector General of the Department of Labor, to identify the efforts his office has made in examining Department of Labor's management of the Federal workers' compensation program.

Welcome, Mr. McBride. Will you please raise your right hand.

Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. McBRIDE. I do.

Chairman ROTH. Thank you. Please be seated. As in the past, you may summarize your statement, and we will include it as if read.[1]

TESTIMONY OF THOMAS F. McBRIDE, INSPECTOR GENERAL, DEPARTMENT OF LABOR

Mr. McBRIDE. I would like to touch on several areas that we have been concentrating on in our work in the FECA program.

The first is claimant fraud. We have not only been investigating cases of claimant fraud and referring them for prosecution, we have also been looking at the claims management process itself. I earlier testified about a project we began in the Atlanta region in November 1980, with seven other agencies which are the employers of the largest proportion of FECA claimants.

What we did was to take the profile of a high-risk claimant in terms of age, type of injury, period on the long-term disability rolls, etc. We attempted through third party sources to verify whether claimants who met the profile had income from other sources, and then conducted file reviews of those and also where we had other evidence of unreported income.

That first project generated 1,800 files which were then reviewed by joint teams in the seven agencies plus my own staff. We found a lot of problems in the files themselves. We found medical evidence that was inconsistent with the injury. We found lack of followup on medical reports. We found little signs of efforts to detect unreported income, and we found deficiencies in the employing agencies' handling of the case itself at the front end, their own accident investigations, and their own attempts to rehabilitate and reassign to other duties.

Of the total files reviewed, 135 were scheduled for investigation and 827 were referred to the Office of Workers' Compensation for follow-up review. This has to date resulted in the termination of 67 claimants which represents an annual saving of about $630,000. If you projected this on the basis of the average length of time a claimant is on the rolls, you are talking about a savings of several million dollars.

---

[1] See p. 60 for the prepared statement of Thomas F. McBride.

Chairman ROTH. Could that be a factor in the increased cost of this program?

Mr. MCBRIDE. It is a factor but it is very hard to quantify how much.

Our experience in Atlanta led us to expand the review into a nationwide project, and having learned from our first effort, we then mounted a training course for about 190 employees from the seven participating agencies and, in effect, told them how to do a FECA file review.

From that second national match, we generated about 10,000 case files for review. Of those 10,000, 2,900 did not have a current statement as to outside income. I think that is very significant because that is the only piece of paper, the only certification by a FECA claimant, that he or she continues to be eligible and does not have another job or other income.

We found 4,000 cases where the reviewers questioned the medical information in the file. We even, in one instance, discovered 28 cases of employees who were being charged to the Postal Service when, in fact, they were employed by other agencies.

Chairman ROTH. Could I interrupt? As I understand, you reviewed 10,000 cases?

Mr. MCBRIDE. That's correct.

Chairman ROTH. Of that 10,000, a total of roughly 3,000 did not contain a current form—what is that current form supposed to show?

Mr. MCBRIDE. It is the so-called 1032 which is the statement of income. It's a certification of income or lack of income.

Chairman ROTH. So 30 percent of them had no information as to whether or not——

Mr. MCBRIDE. No information in accordance with OWCP's policies and procedures.

Chairman ROTH. Then you have an additional 4,000 cases where there was inadequate medical information?

Mr. MCBRIDE. Yes, or conflicting medical information and, again, we tried to follow as closely as we could the OWCP's own policies and not rely on our own independent judgments.

Chairman ROTH. I guess you could say at least half of these cases were not adequately documented.

Mr. MCBRIDE. Yes.

Chairman ROTH. Please proceed.

Mr. MCBRIDE. Of the total of 10,000, about 600 have been broken out for further review, and that really is a precursor to followup investigations.

A substantial portion of those are already under criminal investigation. I can't give you the final figures because the project is still underway.

We have already realized some savings. If you simply look at the annual savings from OWCP's own determinations, we find in the Dallas region, $153,000 annual savings; Denver, $62,000; Philadelphia, $57,000; Chicago, over $1 million. And we are really at the midpoint in this whole project. So I would expect again that the savings will be in the millions when the project has run its course and that we will probably see a fairly high volume of criminal prosecutions.

I should point out that we found quite a wide variance among the district offices, some of which were doing a demonstrably better job in case monitoring and case review than others. I think that reflects a management concern in ESA and a concern I know Mr. Collyer has been wrestling with.

I should point out that our cases have concentrated almost exclusively——

Chairman ROTH. May I interrupt there because I notice in your full statement you say that the smaller offices did a better job than the larger offices. Now, one would assume that in your large offices—New York, San Francisco, Chicago, Philadelphia—you would have some of the best personnel and larger number of experts. How do you account for this difference?

Mr. MCBRIDE. I am baffled myself. I thought perhaps it was because of a predictably larger caseload, in effect, a larger caseload proportionate to claims staff. I got the staffing figures the other day from OWCP, and as far as I can tell, they are allocated apportionate to the volume of claims. I can only attribute it to the quality of management and/or personnel in some of the district offices.

In my own visits around the country to my own field offices, I made it a point to visit OWCP regional offices. I have been in many cases very impressed with the vigor and attention to antifraud/waste issues, and in other regions, have been unimpressed.

One thing I should point out is that most of our cases, and we have had probably about 50 claimant fraud indictments in the last year, have involved unreported income. Those, in effect, are the easy ones—black or white issues. The claimants either had the income, they reported it or they didn't and the violation is rather cut and dried.

The larger question, and one which is very difficult to resolve through a criminal prosecutive process, is the medical condition itself. You get into the arena of disputed medical testimony and proving beyond a reasonable doubt that the medical condition did not exist is a very heavy burden of proof.

To date, we have only had one conviction, a case in San Francisco, involving basic contravention of disability itself—of the medical condition. And I suspect that will continue to be the case, and there, only additional medical reviews and administrative action by OWCP can be effective.

In the medical provider area, generally——

Chairman ROTH. Could I interrupt? In your prepared statement, you say, "To date, OWCP has not initiated any system to routinely identify unreported income. The identification of unreported income is a compliance function that could be easily implemented and maintained."

Why, in your judgment, hasn't the Department done anything about that?

Mr. MCBRIDE. Well, one, I think it is an overreliance on self-certification. That is the form 1032, and any system of verification has to have at least some spot-checking systems for third-party verification. The methods——

Chairman Roth. May I interrupt? They are not even getting the current form for nearly a third——

Mr. McBride. That is a footnote to the problem. The reliance on self-certification obviously depends on having current certifications. We found in many instances those were simply not there. While it is not typical, and I wouldn't want to paint with a broad brush the administrative problem in OWCP, we found cases where people, in fact, reported income which would make them ineligible for the level of benefits they were receiving, and it was just filed and no action taken.

We found forms returned which were incomplete and unsigned with no followup, and we found forms that were sent out and never returned with no followup.

Chairman Roth. It just seems to me if you have a third of those 10,000 with no forms, and there is no followup, that just shows a total lack of internal controls in that area.

Mr. McBride. That is true, but even assuming that administrative problem was cured and you had up-to-date, current, annual, fully filled out certified 1032's, it still doesn't come to grips with the person who is intent on defrauding the Government and is simply lying.

Chairman Roth. Checking; right.

Mr. McBride. And you need third-party verification. The simplest mechanism which is possible in 40 States is to access the unemployment insurance quarterly wage reports. These are quarterly wage reports which contain fairly current data and which are accumulated by the State labor departments, which are funded by the Department of Labor. Matching these data against FECA claimant data will catch most of those who are employed by a reporting employer. It will not catch the person who is self-employed. It will not catch those who go to great lengths to conceal income, but many of our hits that resulted in criminal investigation and prosecution were generated by those simple matches.

I would like to point out, again, that some of the district offices in some of the regions have been considerably more aggressive in going after these unreported income cases. The use of the wage hour investigating staff, I think, is a significant and commendable approach OWCP has taken. I just think that you must use every tool possible.

In many cases, it would seem to me that simple, investigative techniques, such as actually doing a little investigation back at the employing agency as to what old Joe Blow is doing these days might well surface some leads. And, of course, many of these complaints, which go both to OWCP and to us, and which lead to prosecution, come from the anonymous neighbor, who is offended by someone who is ripping off Uncle Sam.

Moving on to the medical provider fraud issue, that, of course, is a significant dollar problem because medical provider costs represent about $120 million of the whole FECA bill. There the standard scams, if you will, are providers billing for treatments that were not rendered at all, that were unrelated to the disability, double billing, even triple billing for the same treatment, and the more serious problem, questionable or false certifications as to the basic medical condition itself.

This subcommittee has already touched on a number of the controls which should be in place to prevent a large volume of this kind of medical provider fraud. One of the major concerns which was triggered by the hearings last July and by our own concerns was the handling of the proven fraudulent situations, the problem of the debarred physicians.

I won't go into great detail about that problem because you and the subcommittee staff are well aware of it. I have been of the view that OWCP does have the authority under the law to debar and that there is no excuse for lack of prompt issuance of regulations.

I have also advocated amending the legislation to make absolutely clear that authority. My view is even if someone were debarred under regulation, at this point, the worse that could happen is be sued and lose, which is better than doing nothing.

Finally, information linkages have to be set up. Medicaid and medicare cost $64 billion a year, but they do have relatively well developed debarment authorities and debarment lists. This kind of information exchange has to be set up with the Health Care Financing Administration, the State medical societies, State workers' compensation programs, all those others who deal with this same provider population.

I am glad to see that the Department's position has changed with regard to debarment authority, be it only recently. While it may not be any large population of providers who will be debarred, I think it will reach some of the more egregious examples that this subcommittee has exposed.

Chairman ROTH. Just let me comment that I think this area shows the total lack of commitment in the program managers to do what is relatively simple. I cannot understand why at this late date they have not followed through on disbarment. It has been pushed, shoved all the way, and I agree with you, that is something that they could borrow, but maybe the agencies don't speak to each other; I don't know.

But we also suggested 8 months ago that they should find out what physicians have been disbarred or put under some kind of administrative constraints in other agencies. But, again, from what you say, no progress has been made in that area.

Mr. McBRIDE. That is correct. I think the recent change in legal position by the Solicitor of the Department of Labor may remove one obstacle to what I hope will be prompt resolution of this problem.

The fee schedule issue, I don't think I need to comment on. It has been the subject of audit recommendations by our staff. I know Deputy Under Secretary Collyer has given very intense attention to that issue, and that there are many problems in imposing it, but I remain dissatisfied, as I was at my last appearance, with the projected 1984 implementation date for medical fee schedules. They are used by the other major health programs, both governmental and private, and should be installed post haste as part of the FECA control mechanisms.

Chairman ROTH. When you say there would be problems in fully implementing the fee schedule before a level II system is operational, what are the nature of those problems?

Mr. McBRIDE. I am not fully familiar with them. For example, I inquired of Mr. Collyer just yesterday about simply adopting the Blue Cross/Blue Shield schedule and was told they treated their fee schedules as proprietary information.

I am fearful that this is an issue that may get studied to death when at least the most common medical procedures should have fee schedules.

I would have to defer to Mr. Collyer to tell you all the ins and outs of that.

Chairman ROTH. What about medicare/medicaid, do they have fee schedules?

Mr. MCBRIDE. They do.

Chairman ROTH. And those are administered by other agencies?

Mr. MCBRIDE. They are administered under the State administered medicaid system.

Chairman ROTH. So there is no privacy in those particular areas?

Mr. MCBRIDE. There is no proprietary problem there. We have been doing a number of other things with regard to the FECA program. One is a more expanded matching effort which is both an effort to detect and prevent fraud and waste and, to some extent, to test the cost effectiveness of some of the innovative matching technologies. We have been matching the FECA rolls against the black lung rolls, matching them against the TVA active employee and retirement rolls, the OPM active and employee retirement rolls, SSI, and VA. Our basic objective is to find whether there are people who are double or triple billing, and ineligibly receiving benefits from two or more programs.

Some of our matches also will look at areas where overlapping or duplicative benefits are legally permitted or where there may be an offset or where the question may be whether there were two separate disabilities compensable under two separate programs. Those match efforts are very, very time consuming and very complex to get going. Compliance with OMB guidelines is required. But we are moving ahead. My expectation is that it will probably be early next year before we have a volume of verification work done so we can say how many verified hits we have, and I shudder to think of the staff resources that are going to be required to verify those because you do come up with literally thousands of raw hits. It may be due to an erroneous social security number; it may be due to legitimate similarity in medical bills; whatever.

One of the other things we are looking at is the death match. You may be aware, Mr. Chairman, of the recent match work done by the Inspector General at HHS, matching black lung benefits, which was formerly a social security program, against the social security death file.

As I recall the numbers, there was a $60 to $70 million savings—or overpayment, if you will—to people who were, in fact, dead and receiving benefits as if living. We are doing that same match with regard to the FECA and black lung programs.

We are also continuing with our audit effort. We have done two major reviews of district office payment operations, and we are doing a more intensive one, focusing on bill payments specifically, and on third party debt collection and general financial management.

Third party debt collection, while it is not a terribly fascinating issue, is one which has large dollar potential. Many FECA disability claimants have a claim against a third party. They were injured in an accident by a taxicab or contractor, or someone else, who is liable.

GAO did a study a few years ago of three district offices and put the potential collection level at $4.7 million. So we think there are big dollars there.

Finally, I would like to comment a bit on the implementation of our past recommendations. Last fall, I advised ESA that we would be conducting an audit of implementation of past recommendations; that is, actually going through the district offices and seeing whether they were doing what the audits recommended be done, recommendations that had been agreed to by ESA management.

We started a financial audit in one district office and work no sooner started than an embezzlement was uncovered initially by an alert bank employee who reported it to ESA and to us, and then our own audit staff discovered another embezzlement. They were directly related to prior recommendations we had made as to cash control, separation of functions, supervisory verification, and so forth. That, obviously, created quite a stir in ESA because there were, if you will, theoretical controls to prevent fraud and waste, and here we found some actual instance of fraud and waste due, in part, to the lack of imposition of those controls.

That somewhat accelerated the attention given to the followup of audit recommendations, and there has been a series of meetings between myself, Mr. Collyer and his staff, and we really are moving in an expedited way, trying to short cut time consuming, district office by district office field reviews to get an accurate picture of the true status of implementation or nonimplementation of key recommendations.

I don't mean to say that if all our recommendations were adopted, we would see and end to fraud, waste, and abuse. It's a program that involves 48,000 claimants on the long-term rolls, and hundreds of thousands of annual payments, both benefit and medical. You are always going to have fraud/waste problems. The best you can do is have cost-effective controls which keep those at some minimum or tolerable level.

I also realize it is very easy to criticize. The task of management, particularly in a climate of resource constraint and austerity, is a very difficult and very challenging one, and there are many fine people, both at management levels and at bill payment clerk levels, in the FECA system. My basic objective as Inspector General is not to be an adversary but an ally. However, if it is necessary to get corrective action, I will and do call them as I see them.

And I think in the audit recommendation area, what we have seen at the top levels, Mr. Collyer's level and his immediate subordinates, is commitment to implementation. But, what we found is all kinds of system problems that do not translate that policy commitment into actual action and implementation at the district office level and, in some instances, the national office level.

These problems are not new. For a major agency like this, it is sort of like turning a big ship around. It takes awhile, and I do not question the dedication and seriousness of Mr. Collyer. But, as I told him recently, until fraud and waste control is a priority equal to that of claims payment, I will not be satisfied.

Thank you, Mr. Chairman. Are there any other questions?

Chairman Roth. Thank you, Mr. McBride.

Why do you think it is so difficult to implement these policy decisions if you say they have got the commitment topside? Why can't they secure the cooperation of the district offices? Is it the old story about the bureaucracy capturing the new appointments? Why is it so difficult to implement these internal controls?

Mr. McBride. I think, it requires sustained personal attention by a very few top people in ESA. You can't count on things being done unless you check. That is the oldest rule of management and many of the audit recommendations which we made, ESA agreed with and we were told they would be implemented, and we found that only when we started to nag did a memorandum go to the field, and often that was months later.

We have so much to do. We can't go around following our own audit steps over and over and over again. We have other areas we must move into.

Chairman Roth. I concur in that. Let's for example, take one of your recommendations. You say, "We had recommended that incoming checks be safeguarded to prevent checks from being stolen. During our survey, we found that checks were maintained overnight on top of desks."

That is not the kind of administrative change that seems to me very difficult for top management to implement. I agree with you, as the IG, you can't be spending your full time following through.

Let me list No. 2:

> We identified inadequate separation of duties in that the bill paying, bill keying and bill filing which should be handled by different staff members who are functionally separated. At the time of our survey, this was not being done. By not having these functions performed by different individuals, the potential for fraud increases substantially.

What I am saying is, top management in Washington, and I think they have got adequate personnel, although that is usually the excuse you hear, ought to be able to followthrough on that kind of recommendation. They are so simple, it seems to me, that it is totally incomprehensible why some of these changes can't be made.

Mr. McBride. Take one example, the one district office where we went out to verify what had or had not been done, we found that security for returned checks was minimal or nonexistent. That related to audit work done a year and a half ago. ESA's response was that the fiscal manual would be revised to extend controls to all fiscal sections. Results from a December review in the district office showed that the revised manual was not yet available; checks were maintained on top of desks overnight; and receipt logs were not properly maintained. You will have to ask someone else why the fiscal manual has not yet been revised and distributed.

Chairman Roth. We have a vote, so I am going to have to temporarily interrupt these proceedings. But I would appreciate it if you would stay until I return.

Mr. McBride. Thank you, Mr. Chairman.

[Senator present at time of recess: Senator Roth.]

[Brief recess.]

[Senator present at convening of hearing: Senator Roth.]

Chairman Roth. Mr. McBride, I am going to ask a couple more questions and then turn it over to Mr. Weiland, staff director, for a few questions he may have.

One of my basic concerns is how do we bring about changes that will make a real commitment within the program to do something about the waste, fraud, and abuse? I don't question the seriousness of this administration or the last administration in desiring to build efficiency in Government. But you look at the record over there of promises where they were going to make changes and reforms and the failure to deliver. It leads one to a conclusion that people come up here and tell us what we want to hear and then think we are going to go home and forget it.

Now, one of my questions to you is, as I understand this particular program, the Department of Labor is responsible for the administration and enforcement of the law, but the costs are paid by the agencies for whom the employees worked.

Mr. McBride. That is correct.

Chairman Roth. Do you think there is a lack of financial incentive to be more efficient, more effective?

Mr. McBride. Yes; but I would say the lack of incentive is in large part at the employing agency itself. I have discussed with Mr. Collyer the possibility of amending the Federal Employees' Compensation Act to change the budgetary incentives. There is a very interesting example. The Postal Service, which is, for all intents and purposes, a private, revenue-based corporation, has the highest FECA claimant load. They instituted a FECA cost control program in Postal several years ago in cooperation with OWCP but largely on their own initiative because they had to bear those FECA costs.

They have reduced FECA costs by almost $30 million.

Chairman Roth. How much total cost for that agency? What percent is that?

Mr. McBride. I have no idea what the total Postal budget is.

Chairman Roth. I meant FECA.

Mr. McBride. I would guess they would be about 40 percent of the FECA caseload.

Chairman Roth. So it's a very significant impact.

Mr. McBride. Yes; if you take Postal, TVA, Department of Defense, Agriculture, DOT, and a few others, you have well over 90 percent of the FECA costs.

Chairman Roth. Mr. Weiland.

Mr. Weiland. Mr. McBride, just a couple quick questions. Can you give us an example or two of the type of claimant fraud that your office uncovered, particularly in terms of possible criminal prosecutions?

Mr. McBride. Well, they tend to follow a fairly predictable pattern. For example, three recent cases involved ex-TVA employees, blue collar employees, who had gone on the disability rolls as a result of back injury, always the most suspicious kind of injury. We found that all three were working while on FECA rolls, working at strenuous jobs, such as pipefitters, which I presume were the same jobs they were doing at TVA and failing to report the outside income to OWCP.

As I recall, the range of payments was from $13,000 to $44,000 for these three cases, and, of course, they were terminated from the rolls, and in these cases, all three were convicted and sentenced.

We had another case in Dallas, which was mentioned to me during the recess. There was a sentencing today where the employee netted over $40,000 in undeserved FECA benefits, a Postal Service employee who was owning three separate businesses on the outside, including a private investigative agency and also had a GSA contract to provide security to government buildings.

We had a Baltimore firefighter retired on disability from a Defense Department agency, who was employed as a roofer, a truckdriver, a bowling alley employee and an installer of aluminum siding. During the investigation, moving pictures were taken of him doing all this work. His employer, interestingly enough, at the aluminum siding company, told our agents that the claimant was "receiving disability and couldn't be caught doing any kind of heavy work."

These kinds of cases are rather predictable cases of people trying to cheat the Government by staying on the FECA rolls.

Mr. WEILAND. As you pursued the Atlanta project, what sort of cooperation did you get from the employing agencies? Do you find them generally aware of the status of their employees on disability or not?

Mr. MCBRIDE. As a result of the Atlanta work, I think they are more aware. We have been working with the investigative or inspector general side of the operations, Postal Inspection Service, Inspector General at DOT, and so forth. And their commitment has been very good.

Agency management, with the exception of Postal and TVA, perhaps, has not been all the good.

I have been very concerned about the employing agency role in all this. My concern is this: Under the system, once you go on the long-term disability roll, as far as the employing agency is concerned, you just drop off the screen. They don't even know who you are any more. You are not their employee.

OWCP has total responsibility for monitoring those cases, and, as we have seen, administrative problems aside, simply because of workload problems, that is a hard task for OWCP to fulfill. And, there are no budgetary incentives for the agencies to control those costs. It's a charge-back system and costs are automatically appropriated by the committees of this Congress.

The Postal Service lesson is that emphasizing the employing agency role and responsibility even after claimants are on long-term disability is critical. Employing agencies must be given incentives to put claimants back on light duty or to rehabilitate them and get them back to work or to get them on the retirement rolls, the nondisability retirement rolls, if eligible, and make sure they have to budget that money at the line item level.

For example, as an inspector general, if I had five disabled employees, and I had to budget those costs every year, predict how much it would cost and put it in my budget figures, I would start looking at it and say, "Hey, who are those five people?" and I would start doing a little work. I don't want to eat that money; I have five positions I want to have filled.

Also, we recommended changing the OPM and OMB regulations to provide ceiling exemptions. Right now, you don't reemploy a claimant because it can take a ceiling slot. That is a disincentive. There are a lot of things that can be done at the employing agency end to strengthen this.

As I said, Mr. Collyer and I discussed it, and we will be discussing it further, and I am sure the substantive committees will be interested in discussing and amending the FECA act to do these things.

Mr. **Weiland**. Thank you, Mr. McBride. I want to take this opportunity, Mr. Chairman, to thank Mr. McBride for the cooperation he has shown me and members of my staff as we worked on this project over the last several months.

Mr. **McBride**. I would like to say you have a very fine subcommittee and very responsible and able staff, Mr. Chairman.

Chairman **Roth**. Mr. McBride, I would like to say that I am particularly interested in your last comments on these other agencies. I think that is something that hopefully the authorizing committees, or, if necessary, this subcommittee, might look into at a later date because I think it is important to see what we can do to develop incentives with them to follow the path of the Postal Service.

Thank you very much.

Mr. **McBride**. Thank you.

Chairman **Roth**. At this time, I would like to call Mr. Robert Collyer, the Deputy Under Secretary in charge of the Employment Standards Administration. Mr. Collyer, would you please come forward and be sworn, as well as anyone else who may offer testimony. Please stand and raise your right hand.

Do you swear the testimony you are about to give before this subcommittee will be the truth, the whole truth, and nothing but the truth, so help you God?

Mr. **Collyer**. I do.

Mr. **Berrington**. I do.

Mr. **White**. I do.

Mr. **Rogers**. I do.

Mr. **Fraser**. I do.

Chairman **Roth**. Please be seated. Mr. Collyer, as is our custom, you may summarize your prepared statement, and it will be included in the record as if read.[1]

Chairman **Roth**. I think it comes as no surprise to you that we are not very happy, and we are interested in learning what you and the others responsible for the administration of this program intend to do. Please proceed.

TESTIMONY OF ROBERT B. COLLYER, DEPUTY UNDER SECRETARY, EMPLOYMENT STANDARDS ADMINISTRATION, DEPARTMENT OF LABOR, ACCOMPANIED BY CRAIG BERRINGTON, ASSOCIATE DEPUTY UNDER SECRETARY, EMPLOYMENT STANDARDS ADMINISTRATION; HENRY WHITE, DEPUTY DIRECTOR FOR PROGRAM OPERATIONS, OWCP; LAWRENCE ROGERS, DIRECTOR, OFFICE OF PROGRAM DEVELOPMENT AND ACCOUNTABILITY; JOHN FRASER, SPECIAL ASSISTANT TO MR. ROGERS

Mr. **Collyer**. Thank you, Mr. Chairman. I am Bob Collyer, Deputy Under Secretary. With me is Craig Berrington, Associate Deputy Under Secretary, to my immediate right; Lawrence Rogers, Director of the Office of Program Development and Accountability, on my immediate left; Henry White, Deputy Director for Program Operations, Office of Workers' Compensation Program, to my far right; John Fraser, staff assistant to the acting director, Office of Administrative Management, on my far left.

---

[1] See p. 74 for the prepared statement of Robert B. Collyer.

Mr. Chairman, let me point out that I have also invited to these hearings today Mr. Garcia who is our regional ESA Administrator in Seattle, Washington, and Mr. Stewart Glassman, the Assistant Regional Administrator for the Office of Workers' Compensation Programs, Kansas City. I wanted them to see these proceedings and carry back to the field the feeling, the aura around these hearings.

Chairman ROTH. Very good. We welcome them here today.

Mr. COLLYER. They are in the audience, if you or your staff would care to interview them before they go back, they will be around today. I don't believe you have been in either of those offices. They will be happy to talk to you about any questions you have.

Chairman ROTH. Good.

Mr. COLLYER. We also have representatives from the Solicitor's Office here as well, if you have questions.

Mr. Chairman, members of the subcommittee, I appreciate the opportunity to appear before your subcommittee today to discuss our efforts to improve the administration of the Federal Employees' Compensation Act.

While I am here to explain the specific administrative actions that we have taken to effect improvements, particularly those we have taken since the hearings of this subcommittee last July, let me make clear, as I have repeatedly stated since taking office, that administrative changes alone cannot restore the credibility of the FECA program, nor eliminate its inherent flaws and inequities. Legislative changes are needed to accomplish these objectives.

Today, the Federal compensation system has an overly generous benefit structure which actually provides incentives to file claims for minor, non-disabling injuries and to stay off the job for more time than is necessary.

The administration transmitted legislation to the Congress last year to address inequities in the current law. It will be resubmitted shortly and will include a number of items of specific interest to this subcommittee, such as provisions dealing specifically with medical provider fraud and abuse, fee schedules, improved information in the earnings of disability recipients, stronger penalties for fraud or misrepresentation, and more.

We are indebted to you, Mr. Chairman, and to the subcommittee staff, for your diligence in pursuing these concerns.

Let me also emphasize my continued belief that the key reform at the administrative level is modernization of the program through the implementation of our long-range automated data processing system. The first phase, level I, of the ADP system was fully implemented in the fall of last year with the installation of the automated compensation payment system in our district offices.

Level I provides the following: An automated compensation payment system; improved tracking of case location; claims adjudication status; and case workload distribution within each of our offices. Level I also provides for a bill payment and audit control system and surveillance reports.

The level II system will structure and control the claims adjudication process to insure that claims examiners must follow and meet prescribed evidentiary steps before a decision can be rendered. Level II also will automatically examine bills against accept or reject codes, screening bills to assure they meet criteria for accepted conditions, frequency of service, appropriateness of treatment and reasonableness of costs.

We expect to have level II fully implemented during fiscal year 1984, and we believe that this level II system fully addresses major operation and security problems. Our firm commitment to ADP modernization is reflected in the Department's fiscal year 1983 budget submission requesting a $3.8 million increase over the pending fiscal year 1982 budget of $14.1 million for ESA ADP development. Of the $17.9 million requested for ESA ADP development, $10 million will be expended on FECA ADP development.

While legislation and full implementation of our ADP system are the essential prerequisites of permanent reform, there are a number of actions that can be and are being taken now, within the context of existing legislation, current ADP capabilities and resource levels, to prevent fraud and abuse. Even though taken in total they can have a significant impact on the program, these actions individually often appear less significant in nature, and thus have in the past often not received the priority and followup monitoring they deserve.

To prevent this from happening in the future, ESA, and the Office of Inspector General, have undertaken a cooperative arrangement to monitor ESA's progress on the implementation of recommendations for improvements made by the Inspector General, the General Accounting Office, and the congressional committees.

In August 1981, I established an "Internal Control Unit" to coordinate antiwaste, fraud, and abuse efforts with the OIG and to strengthen ESA's own ability to deal with these related problems. The ICU has full responsibility to evaluate all ESA systems, to identify irregularities and to recommend corrective actions. And on matters of fraud, waste, and abuse, our ICU reports directly to me.

The Department of Labor, and my staff and I personally, are committed to achieving implementation of waste, fraud, and abuse protections in the day-to-day operations of the Office of Workers' Compensation Programs. I believe our progress to date reflects that commitment, and I would now like to briefly address our actions in that regard in six distinct areas: Claims processing, case management, medical support and guidance, vocational rehabilitation, training and technical assistance, and bill payment system security.

CLAIMS PROCESSING

Procedures issued October 1, 1981, provide for early notification to claimants that their claims are invalid or insufficiently documented. Prior to these procedures, claims with insufficient documentation were left open. Under our new system, 10 days after receipt of an unsupported claim of traumatic injury, a notice is issued, and the claim is denied if no additional evidence is submitted within 45 days.

Undocumented occupational disease cases are denied after a second warning and within 180 days after filing the claim. The results have been that in the first quarter of fiscal year 1982, 86 percent of traumatic claims have been adjudicated within 45 days as compared to 63 percent in the first quarter of fiscal year 1981.

In the first quarter of fiscal year 1982, 56 percent of occupational claims have been adjudicated in 180 days as compared to 42 percent in the first quarter of fiscal year 1981.

Also, in the first quarter of fiscal year 1982, 54,000 cases were adjudicated overall, or 30 percent more than were received.

Claims for low-back injuries or conditions comprised almost 18 percent of reported injuries. In June 1981, a pilot project was established with the Postal Service in San Francisco, and another in January 1982 in Washington, D.C., to speed the return to work of such claimants.

In San Francisco, claimants are contacted within 3 weeks and referred to impartial specialists if the injury is likely to exceed 30 days. In Washington, D.C., district office claimants are contacted within 7 days and referred to specialists for injuries of 7 days or more. Of 509 low-back injuries identified in San Francisco, 86 percent returned to work within 30 days. Of 50 such cases in Washington, D.C., 36 percent returned to work within 7 days.

CASE MANAGEMENT

To tighten our case management, we have instituted several improvements:

Quality control units, now in place in district offices, have been assigned the management control functions of making representative sample quality checks of initial adjudications, continuing daily roll payments, periodic roll reviews and bill approvals.

All compensation payments now require the certification by a supervisory claims examiner or designated substitute. Schedule awards require certification both by supervisors and the Chief, Branch of Claims. These procedures provide greater control over payment and insure that claimants are not placed on the long-term rolls without supervisory review.

Periodic review of long-term disability cases have been intensified. These reviews provide for more frequent evaluations of the claimant's current medical condition, whether he has stabilized or completely recovered, to determine the current level of disability and whether or not continued compensation is warranted.

For fiscal year 1981, 52,000 cases were reviewed. As a result, 2,000 cases were adjusted downward to reflect partial earning capacity and 2,700 cases were removed from the rolls, yielding savings of $22 million. This is up from the $17 million saved in fiscal year 1980.

We have expanded the use of wage-hour program compliance staff to investigate suspect cases. Since the program started in October 1980, 304 cases have been referred to compliance officers for investigations. A total of 199 investigations have been completed; 105 investigations are continuing; 14 cases were referred to the OIG for investigation. Of these, 8 cases were found to involve potential fraud. Savings from the 185 completed investigations are estimated at $46,000 in monthly compensation.

MEDICAL SUPPORT AND GUIDANCE

We continue our efforts to increase the quality of medical standards for processing of occupational disease cases.

In August 1981, detailed procedures for adjudicating asbestos-related claims were distributed with instructions for obtaining adequate information from agencies, claimants, and physicians. Asbestos exposure accounted for 1,719 new claims in calendar year 1981, and is becoming an increasing factor.

We are increasing our ability to handle radiation-related claims by establishing a contract with the National Council on Radiation Protection. This will significantly enhance our ability to evaluate such cases.

Examiners receive training from local medical specialists in other common disease conditions, particularly heart, low back, psychiatric and respiratory complaints. District offices now use 65 consultants in a wide range of specialties, such as cardiology, orthopedics, and neurology, to buttress the work of medical directors in the early evaluation of medical evidence.

The results of aggressive initial case development show in these statistics: As of January 1982, we had adjudicated 364 heart cases received in calendar year 1981, approving 49, or 13.5 percent, and denying 315, or 86.5 percent. We adjudicated 446 cases of stress-related emotional disorder, approving 79, or 17.7 percent, and denying 82.3 percent. Of the 1,215 respiratory cases adjudicated, we approved 679, or 55.9 percent, and denied 44.1 percent.

I intend to establish the position of medical director for all ESA programs, to replace the former medical director position which was responsible only for OWCP programs. Recruitment for this position will be difficult if our recent experience over the past 8 months in attempting to obtain suitable applicants for the vacant OWCP medical director position is any guide.

We are intensifying our efforts to attract the best candidates by advertising in a variety of publications. We hope that these efforts, combined with the broader scope of responsibilities, raised pay cap for Federal employees, and bonus payments available for medical doctors will enable us to recruit a high-caliber individual for this position.

VOCATIONAL REHABILITATION

In the area of vocational rehabilitation, we have done the following:

In fiscal year 1981, over $7.5 million in FECA compensation costs were saved by the successful rehabilitation of 763 workers, 450 whom were reemployed under the Department of Labor-Postal Service rehabilitation agreement. This represents an increase in savings of $2 million over fiscal year 1980.

In fiscal year 1981, about 7,600 employees were screened for vocational rehabilitation services. About 2,214 were accepted for services.

Since its establishment in fiscal year 1980, some 618 workers were reemployed under the Department of Labor-Postal Service rehabilitation agreement. The number of rehabilitated workers reemployed increased from 168 in fiscal year 1980 to 450 in fiscal year 1981.

In November 1981, we initiated a pilot project in the Chicago district office to increase the number of injured workers rehabilitated and the timeliness of services through the use of the ADP system and expanded use of private rehabilitation agencies. The evaluation of the project will be completed by August of this year.

TRAINING AND TECHNICAL ASSISTANCE

To improve quality control of the FECA claims management and adjudication process, we have carried out an extensive program of staff training and technical assistance to other Federal agencies and within the program.

Since 1978, newly hired examiners have received comprehensive training in all aspects of claims adjudication. To date, a total of 267 new examiners have received the training, and 286 examiners have received the advanced training course.

In calendar year 1981, 99 training workshops were held for 1,010 compensation specialists in approximately 50 employing agencies and their sub-units.

During August to November 1981, training in FECA processes was provided to OIG investigators as part of their review of the periodic long-term disability rolls.

During October 1981 through March 1982, technical assistance was provided for OIG's review of existing agency regulations and procedures impinging on FECA claims, and of agencies' interrelation with OWCP.

We have completed course development of a formal training program for bill payment clerks. The course includes a text and handouts for trainees to instruct bill payclerks in reviewing bills for relationship to accepted condition, relation to basic medical reports and reasonable length of treatment. Pilot sessions will be held April 6 through 7, 1982, in the Washington, D.C. district office and the Branch of Special Claims.

BILL PAYMENT AND SYSTEM SECURITY

The subcommittee has expressed concern about our ability to control bill payments without a fee schedule. A fee schedule is something we intend to do in connection with our level II ADP system, as I shall describe in a moment, and a provision specifically providing for it has consequently been included in the administration's FECA legislation.

Let me assure you, however, that even in the absence of such a system, we do have a number of significant controls on bill payment. Automated controls have resulted in the rejection and subsequent individual review of 44,900 of the 662,000 bills received in fiscal year 1981. They included payments totaling $7.3 million. I will now discuss some of the most significant controls.

Instructions were issued requiring bills for office visits more than 3 months after injury and visits billed in excess of $75 to be approved by the bill-pay supervisor. Cases in which excessive care follows a minor injury are referred to a claims examiner for review.

Monthly bill payment surveillance reports are now sent to all district offices. The report identifies medical providers receiving over $1,000 for the period covered, or more than $500 on the average per case, and medical providers with five or more cases. Bills submitted by identified medical providers are subject to closer scrutiny by claims examiners and supervisors.

We are now producing reports at the district office level which show all transactions for one medical provider in a given time period. Previously, reports had to be requested specifically from the national office.

Our ADP system rejects bills paid against false names, nonexistent cases, and cases closed more than 30 days and requires authorizing initials for bills in excess of certain dollar amounts. It also rejects any duplicate or overlapping payments and will shortly be modified to reject payments to a provider not entered into the system in advance.

We now issue quarterly reports to employing agencies, listing names of claimants and types and amounts of payments charged. Agencies can review and notify OWCP of improper or questionable benefit payments.

We now have the computer capability to produce a report to each claimant of the services paid by OWCP and to medical providers showing charges paid by OWCP, to enable verification that services were actually performed. Reports for payments in the third quarter will be mailed to claimants in July. A small sample mailing to providers will also be issued in July.

The subcommittee has expressed concern about two important issues, the exclusion of fraudulent medical providers and the adoption of medical fee schedules.

On March 26, 1982, Secretary Donovan advised you by letter—a copy of which is appended to this statement—that the Solicitor of Labor has concluded that the Department does have authority to issue regulations——

Chairman ROTH. Mr. Collyer, I have to go and vote. I will temporarily interrupt.

[Senator present at the recess: Senator Roth.]

[Brief recess.]

[Senator present at convening of hearing: Senator Roth.]

Chairman ROTH. Please proceed, Mr. Collyer.

Mr. COLLYER. Thank you, Mr. Chairman.

On March 26, 1982, Secretary Donovan advised you by letter, a copy of which is appended to my written statement, that the Solicitor of Labor has concluded that the Department does have authority to issue regulations which would exclude fraudulent medical service providers from participating in the FECA program. Action to develop such regulations has been initiated.

As indicated in that letter, however, we continue to favor and prefer the enactment of legislation that would unequivocally grant such authority, and it is for this reason that——

Chairman ROTH. Mr. Collyer, I wonder if I can ask you to summarize. I am concerned we are going to have another vote in the near future. I would like to complete if we could.

Mr. COLLYER. I will just stop. You have the statement in the record. We can proceed with questions.

Chairman ROTH. Mr. Collyer, as I listen to you, in contrast with the witnesses before, I would come to the conclusion that everything is all right when, in fact, I do not find that to be the case. I would just like to underscore the fact that this administration has dedicated itself to make Government efficient, to eliminate waste, fraud, and abuse. As a matter of fact, in the proposed budget, there are some very substantial savings the President proposes to be realized through elimination of inefficiencies, but I must confess that I am extraordinarily concerned that in FECA, I don't see the dedication or commitment that I think is essential to bring about the kind of improvement that I think is necessary.

I would just point out to you the chart on your right listing the DOL broken promises to improve FECA. One of your promises is that in 1984, you will put in place, what do you call it, level II?

Mr. COLLYER. Level II.

Chairman ROTH. I think that initially that was supposed to be completed by fiscal year 1979. In any event, perhaps it is necessary to have a time delay to put in a complicated, sophisticated system, but I don't think we can afford to wait 2 years.

No. 1, it is postponed so long that by 1984, when we have a new election, maybe it would all be forgotten anyway. But I would ask your comments—of course, much of that happened before you were there. You are not personally responsible, but I am concerned that I really haven't seen that much progress in the last 8 months. I don't see where the situation is that different.

Let me just go down through some of these things that we talked about.

One, OWCP said it would obtain and use fee schedules, and the original target date is 1981. Now, today you are saying that that will be incorporated as part of level II in 1984. That is 2 to 3 years in the future. I can't understand why we have to wait that long for a fee schedule; why you can't borrow from one of the other agencies and put it into effect.

I am shocked, to be candid, by testimony today, sworn testimony, that the district offices have received no instructions about the reasonableness of fees. Why can't you go back today and in the next 2 months, 3 months, give some instruction, give some fee schedules that are already in use by Government as well as in the private sector? I find it very difficult to understand why it can't be done.

Mr. COLLYER. Mr. Chairman, let me take full responsibility for the fact fee schedules are not in place in the FECA program today. I have not personally promised anyone that we would use a specific fee schedule. The promise that was made, as I recall from discussions with staff, is that the field would be advised to use any and all available fee schedules to determine whether or not the fees are reasonable fees under the circumstance, but not that any particular schedule would be adopted as a Federal schedule or FECA schedule.

When I first arrived in my new job, it was my intention to adopt a relative value fee schedule. This type of schedule uses points to relate the relative difficulty of one procedure to another. I intend to install relative value fee schedules on a nationwide basis. I was told by staff that this particular system would be installed in the level II ADP program.

My next step was to consider, since we had some time, farming out to individual accounting agencies, private contractors, the auditing of these bills, not only the doctors' bills, but the hospital bills and certainly the pharmacy bills. I have known in the past people who are in that business and they claim, and apparently do, achieve substantial savings. But they have large data base.

I asked if we could sign a contract right away with a contractor who I am familiar with to audit prescription drug bills from both hospitals and medical providers and the pharmacies, and I was told we had to go through the procurement process, which is the first time I heard that, but for the first time, I became familiar with it completely—a long, drawn out process. We are not finished with it yet.

Chairman ROTH. How many months does the procurement process take?

Mr. COLLYER. When I first started talking about it, it was October or November of last year. The request for proposal has been issued to the public for proposals. Responses are due no later than April 14, 1982.

What I want to do in short order is prove there are substantial savings out there. Actual dollars can be saved by the Federal Government through the two pilot projects. One would be just for the pharmacy bills. The other would be for total care, medical services and all the rest—hospital services. So, we are now conducting two separate pilot projects, total care in San Francisco; prescription drugs in the Dallas region.

Chairman ROTH. Are these pilot proposals or are you talking about the entire country?

Mr. COLLYER. They are pilot projects in those two separate regions. The results of the projects will provide the data so we would have control as to which is needed to determine the best way to go, and I would be able to sell that to the administration for eventual nationwide expansion.

There would be costs involved. I couldn't guarantee any one that the proposals would be cost-effective until we conducted a pilot project. It was my intention to do that 6 months ago. The procurement process apparently is just much slower than that. We still intend to do that.

Recently, I thought even though those pilot projects are in place, we could probably adopt a fee schedule by visiting, maybe, the American Medical Association. I suspect that the AMA has a subbcommittee on fee schedules. I certainly would suspect they have adopted relative value schedules. One of them should be fair. We could put one into our computer right now, announce it, publish ads in the newspapers, send out copies to everyone. This would permit us to be billed based on the codes by the treatment provided so that the auditing would be pretty much done by the time we got there.

This is what we will have in our level II system except the computer will make the determination as to whether the billing is proper, and all the other things that go well beyond the fee schedule.

I am convinced right now we should look at farming out the services if it's cost effective, efficient, and enhances our ability to pay on time. We may want to drop the bill payment service from the ADP. But, at least with respect to the prescription drugs, it leaves out the other controls that will be in the computer program.

So I favor that. It is going to take some time to get there. I want to let my staff at this table—for whom I have a great deal of respect, and who are intelligent and have good ideas—amplify or correct anything I say, if that is all right with you.

Chairman ROTH. Time is short. Just let me make a comment. No. 1, if I understood your testimony, you were saying you were going to have a fee schedule by 1984. Now, I understand you are talking about a value schedule. I don't pretend to be an expert in this area, but let me say that I would hope that in any agency, including yours, in setting up whatever you ultimately do, it should not be totally based only on AMA. Frankly, I am shocked, according to our witnesses today, that there has been no disallowance for unreasonable fees. I think this is something that your program can learn from some of the other agencies and maybe there is merit to your new idea.

I am not passing judgment on it, but I am saying that now it is April. Originally, OWCP was going to obtain and use fee schedules in 1981. And now we are talking about some model plans, pilot tests with a target date for fee schedules in 1984. Frankly, I am confused and not satisfied. I think something has got to be done much more quickly than you are proposing.

It is all very well, and I applaud any new ideas and testing and pilot approaches, but the problem is today. I just would go to the testing of the national FECA project made by the Office of Inspector General where they reviewed over 10,000 separate files and found major problems. They found, for example, of those 10,000—I am sure you have seen this national FECA project—3,000 didn't contain 1032 current vouchers, or whatever you call them. That is the idea of checking to make sure about outside income.

What steps have been taken to correct that situation, Mr. Collyer?

Mr. Collyer. I am not certain because I have not seen the case files, reviewed by the Office of the Inspector General. The annual wage certification statement may show reported earnings, as noted by Mr. McBride, and still be legitimate. Since this is a wage replacement system, a claimant who cannot return to his regular Federal job may earn some wages, and his compensation is adjusted to reflect his ability to earn.

Chairman Roth. What I am saying, as I understand the schedule, is that of the 10,000 cases, roughly 3,000 contained no current 1032 statements.

Mr. Collyer. These are annualized and they are sent out. The claimant is expected to sign the form and send it back in. If it is not in, it is resubmitted. That would take you past the date when it would be current. It would be noncurrent but in the process, the claim would be identified.

Chairman Roth. There was no indication they were in process. Have any steps been taken to insure every case maintains a current 1032 statement?

Mr. Collyer. We do a periodic review every year of each case. The CA-1032 statement is certainly one of the first forms checked. If a claimant is 70 years old and totally disabled, the receipt of that form doesn't mean a great deal.

Chairman Roth. Well, Mr. Collyer, this is 3,000 cases out of 10,000. I don't think these are retired people. Frankly, I think that is an unacceptable rate. Obviously, there could be some error, and we are not asking for perfection.

Let me just go through some of the other things. Of those 10,000 cases, over 4,000 of them did not have current medical information. What rationale can there be for that?

Mr. Collyer. Again, it depends on the kind of case. Some cases don't require current medical treatment; the condition is static; it will not change. If the disability is rather severe, the work status will probably go unchanged. I can't speak to the 4,000 cases because I have not seen or reviewed them. There is probably some slippage.

Chairman **Roth**. That is not slippage. Let me point out the IG investigation is based on your own guidelines. There is no way, in my judgment, you can rationalize that 3,000 don't have a current 1032; that over 4,000 don't have current medical information. I think that is one of the reasons we are finding so much fraud and abuse.

Mr. Weiland, do you have any questions?

Mr. **Collyer**. I think Mr. Berrington wants to make a comment on that.

Mr. **Berrington**. Mr. Chairman, the OIG project was an important one which we participated in and, indeed, we trained the OIG people. The training program that Mr. McBride mentioned was one that OWCP set up; we trained the OIG folks, and we have gone through the files with them.

Chairman **Roth**. I really don't care——

Mr. **Berrington**. But——

Chairman **Roth**. Excuse me. I don't care who set it up; who did the training. The results are not satisfactory. They are not satisfactory by your own guidelines, and I am really not interested in hearing any excuses. To me it is shocking that you would come up and try to defend that.

Mr. **Berrington**. Mr. Chairman, I am not offering an excuse. What I wanted to say was that we have a process that we go through every year in reviewing long-term cases. Of the 52,000 long-term cases reviewed, we removed or reduced benefits in over 8 percent of those cases last year. About 5,000 people were either removed from the rolls or had their benefits reduced.

It is a continuous management process that one undergoes because people who have been injured and who may not be reporting regularly what their current status is.

Chairman **Roth**. You can always rationalize——

Mr. **Berrington**. I am not rationalizing, sir.

Chairman **Roth**. It is not satisfactory. I can see no reason for this kind of performance. Your own IG has testified that there are not adequate controls and that is the purpose of his job, and he makes his investigation based on your guidelines. Let's proceed.

Mr. **Collyer**. I will look into that personally, Mr. Chairman. I will find out what those 4,000 cases were, and we will make sure we have adequate controls.

Chairman **Roth**. Mr. Weiland.

Mr. **Weiland**. Getting back to that same point, I guess what is somewhat confusing to the staff is, given this annual file review conducted by your own people, how is it that Mr. McBride's Office could come up with these additional deficiencies if, in fact, your Office is reviewing each and every claim that is filed annually?

Mr. **Berrington**. I would have to get into that more specifically with Mr. McBride, but the point is that you don't review every case every week. Conditions change within the year. We have large numbers of cases that we review. In the level II system, and I must say, we have never made a promise on that level II system or the level I system that we haven't kept, when that level II system is in place, every periodic case will automatically come up every year for review and it will be on a scheduled basis.

Until we install that system, and it is on track, we have a pilot operation going in district 25 here in Washington, D.C.—I am sorry if you didn't get a chance to see it; House staff did. It works very well. It is a difficult system to get in place. Those periodic roll reviews will come up automatically and the review will be done. But people's conditions change during the year and at any snapshot point, you are going to find that there are situations that are not reflective, in reality, of what is in the file.

Mr. **Weiland.** One other question. I am a little confused about this computerized bill-paying system that is designed to reject false and duplicative bills. We are aware of what appears to be a very large scale embezzlement in one of your offices on the magnitude of approximately $300,000 by your own bill-paying clerks, apparently.

How can you explain that situation?

Mr. **Berrington.** Of course, the matter is under investigation, but Mr. Fraser, I think, can respond as to what the current ADP system does, and what the level II will do and just what happened in that particular situation.

Mr. **Fraser.** The computer audit built into the existing bill payment system provides checks which require supervisory authorization to override. In this particular instance that you mentioned, the supervisor was allegedly involved in the episode.

One of the redundancy checks which required supervisory review appears to have been rendered inoperative in that case.

Mr. **Weiland.** Did you have a prior warning from the Office of Inspector General that your control measures were inadequate and that just such an embezzlement might occur if you did not change it?

Mr. **Berrington.** The suggestions that we had from the OIG, which we agreed with in the broad outlines, is that responsibilities ought to be separated out in various different segments of the organization.

What they specifically recommended to us wouldn't have prevented this case from occurring, but we have gone beyond their recommendation and are implementing a procedure in which only a high level systems manager will be able to input information into the ADP system. That should prevent repetition.

Mr. **Weiland.** Thank you, Mr. Chairman.

Chairman **Roth.** One of the recommendations of the IG was to separate the staff duties of the billpaying, billkeying, and billfiling, to have those performed by different staff to avoid the opportunity for fraud.

What steps, Mr. Collyer, have been taken to implement that recommendation?

Mr. **Collyer.** We sent out instructions, Mr. Chairman, to correct that, to separate those functions. We have asked the offices to respond by telephone as to whether these procedures have been implemented as yet.

Mr. **Rogers.** In general, these functions have been separated.

Chairman **Roth.** When did the written instructions go out?

Mr. **Rogers.** October 1981.

Chairman **Roth.** October 1981?

Mr. **Collyer.** Yes, sir.

Chairman **Roth.** Is the IG still here?

Mr. **Rogers**. The IG Report was in September, I believe.

Chairman **Roth**. September of what year?

Mr. **Rogers**. The IG Report was last September.

Chairman **Roth**. Do you say in all cases that these have been separated?

Mr. **Rogers**. I said in general they have been separated, not in all cases because some places we are having space problems.

Chairman **Roth**. How many offices have been separated? What offices?

Mr. **Rogers**. To go by region, if I could——

Chairman **Roth**. Why don't you just submit that to us in writing, if you would.

A final area I would like to ask, where are we now on disbarring physicians who have a history of abuse in submitting fraudulent claims?

Mr. **Collyer**. The Solicitor has given us an opinion that we have the authority to write regulations that would provide the authority for us to debar physicians that are proven guilty of fraud.

I would hope, and I would expect, this would be the case where a physician openly defrauds a FECA program, and we discover it. That the physician be blackballed. Certainly that would be the least we could do, and just not pay any more bills submitted by that physician. We can't take public action, but we certainly can do that.

Mr. Fraser tells me the computer can be set up in any number of ways to prevent another check from going to that doctor just by changing his address at the district office so the check comes back as a failsafe device. There are a number of ways to prevent that.

I have some concerns if our regulations are not very carefully drawn that we might, because of some information we might receive through the newspapers, or whatever, try to debar a physician who may be subject to charges filed by some other program. It may not even involve medical or mail fraud, and I think that debarment of such physician under the FECA program would be risky. It will take us——

Chairman **Roth**. Mr. Collyer, are you concerned about the tax dollars being wasted?

Mr. **Collyer**. I certainly am.

Chairman **Roth**. Now, how long is it going to take to issue those kinds of regulations? It took your solicitor 7 months to finally come up with an opinion that this could be done. How long is it going to take to issue this kind of regulation which is already in effect in other agencies of the Government?

Mr. **Collyer**. I asked that question, and I don't like the answer. I hate to even give it to you. The entire process may take 6 months. I admit I have been involved in other programs where we are redoing regulations. That is a long, laborious process. I don't think this would take as long as that has taken, but you can't do it overnight.

Chairman **Roth**. In the meantime, the Government could be losing millions of dollars. Frankly, again—I have no further questions at this time—I just want to underscore I see no great commitment, no concern about needing to provide some real internal controls. The fact that you are going to have a complicated, sophisticated system in 1984 does not excuse us from taking measures today to try to correct it.

◆

Frankly, a sophisticated system of 1984, whether it is computerized or otherwise, depends upon the information you feed into it.

Now, Mr. Collyer, I really am deeply concerned that we are not making, and I realize you haven't been there too long, the kind of progress I think is essential, and I want to make it very clear to you that this administration and this subcommittee is going to continue to monitor this. We are going to have further hearings, except next time, unless we become confident progress is going to be made. we are going to have the Secretary of Labor come before us and testify.

I will ask you to give us a progress report every 3 months. We will send you a letter detailing some of the information that we would like. I would ask you to advise us on a quarterly basis what kind of progress is being made. I intend to not only submit the results of the hearings today to Senator Nickles and others, but to OMB who has the responsibility for management, to have them look into it because I am concerned that we are not doing everything that needs to be done to insure that this program is properly administered.

I am not satisfied with the kind of progress that is being made. I think much more remains to be done.

Mr. **COLLYER.** We will certainly concentrate our efforts and will cooperate with the staff of the subcommittee to every extent possible.

Chairman **ROTH.** We will leave the record open for a couple of days in case other members of the subcommittee have written questions that we will ask that you respond to.

The subcommittee is in recess.

[Whereupon, at 12:40 p.m., the subcommittee recessed, subject to call of the chair.]

[Statements of Mr. Cox and Mrs. Hainer; Mr. McBride, and Mr. Collyer follow:]

APPENDIX

PREPARED STATEMENT OF

HOWARD W. COX, STAFF COUNSEL; & KAREN A. HAINER, STAFF INVESTIGATOR

Mr. Chairman and Members of the Subcommittee:

Exactly one year ago, Mr. Chairman, you asked the Permanent Subcommittee on Investigations (PSI) to assess the vulnerability of the federal workers' compensation program to fraud, waste, and abuse. Eight months ago PSI presented its investigative findings to you and the Members of this Subcommittee. At the hearing held last July, it was clear that the Department of Labor's Office of Workers' Compensation Programs (OWCP) does not protect itself from avarious and criminal medical providers, from fraudulent claims submitted by federal workers, or from waste bred by inefficient and costly administrative practices.

From the beginning of these hearings last July, Mr. Chairman, you advised Department of Labor representatives that it was your intent to monitor follow-through steps taken to correct the serious problems in this program. You expressed your grave concern that every corrective action promised by the Department seemed to be off in the future at some later date - yet you noted that in looking back five years to reforms suggested in 1976 that it was difficult to see what real progress has been made in instituting internal controls.

Now we must report to you again that, although some progress towards implementing protections against fraud and waste has been made, it appears that more must be done to make good on DOL's constantly recited commitments to put this program in order.

We will highlight several recommended ways of attacking fraud and abuse, such as an internal suspension/debarment mechanism for medical service providers and a comprehensive policy regarding the medical aspects of claims processing, and then demonstrate the continuing inability of the Department to resolve these issues. We will also demonstrate that this litany of broken promises has its consequences in program dollar losses. (Exhibit 1)

Since the July hearings the staff has continued to spend substantial time on this project. We have spent almost two full weeks working from the Boston district office, where we reviewed over three hundred claimant files, and we have visited the Dallas and Philadelphia district offices as well as the two offices in the Washington, D.C. area. We have contacted, either by phone or in person, every district office. Numerous claimants and federal agency officials who participate in the workers' compensation program have been interviewed.

DOL SUSPENSION AND DEBARMENT AUTHORITY UNDER CURRENT LAW

At our last hearing we highlighted the fact that if a physician defrauds the government, and is convicted of that fraud, the Department of Labor will only exclude that physician from participating in the federal workers' compensation program if he is stripped of his license to practice medicine. Representatives of the Labor Department testified that a suspension/debarment system based on the provider's prior criminal conviction had never been formally proposed to the Secretary of Labor.

The Department of Labor program administrators who testified, however, speculated that a suspension/debarment system could not be developed under current regulatory authority.

In an effort to clarify this testimony, Chairman Roth wrote to the Secretary of Labor to inquire whether the Department, under current law and regulations, has the authority to deny or exclude medical providers from participating in the federal workers' compensation program. Secretary Donovan responded the Department did not have authority, although the matter was to be studied further. Last Friday, March 26, 1982, Secretary Donovan wrote to say that he now agrees the Department has authority under current laws and regulations to suspend and debar convicted doctors. However, the Secretary noted that specific legislation covering this issue would aid the Department.

In the seven months since Secretary Donovan notified us that his legal counsel would research suspension/debarment authority, the Department of Health and Human Services (HHS) has continued to suspend and exclude Medicare practitioners under 42 USC §1395. And it has come to our attention that in at least one instance an osteopath found not guilty by a jury of Medicare and Medicaid fraud was nonetheless administratively barred from Medicare by HHS because his billing procedures were considered sufficiently irregular to warrant action. (Exhibit 2)

The Department of Labor has made clear to the Subcommittee its longstanding view that the Secretary's authority under the FECA statute to determine "qualified" physicians must be extended to all except those providers whose licenses have been revoked. But, as Senator Cohen pointed out during our last hearing, physicians' licenses are rarely revoked - criminal convictions notwithstanding. Moreover, both Senators Cohen and Rudman emphasized their view that it is unconscionable for the Department to delegate to professional societies its responsibility to the American taxpayer to control abuse.

IMPROPER RELIANCE ON MEDICAL SOCIETIES

Since the Department of Labor relys solely on the medical profession to rid itself of abusive providers, we have examined the track record of these societies and their actions to revoke medical licenses with respect to the three doctors cited at our last hearing. The information we obtained leads us to observe that self-regulation by the medical community is inadequate to protect the government's interest.

Our previous investigation into fraudulent providers in this program concentrated on the treatment and billing procedures of Dr. Allen Josephs, a New York osteopath. Dr. Josephs, convicted of private insurance-related mail fraud, was serving his sentence in a federal penitentiary at the time of our last hearing. No action to revoke Dr. Josephs' authority to practice medicine was initiated until after his release in January, 1982. During this past month, the Board of Professional Medical Conduct in New York held a hearing to consider revocation of Dr. Josephs' license. The decision of the Board has not been made public to date. Additionally, the state workers' compensation board, acting on a recommendation from the New York Osteopathic Society, formally revoked Dr. Joseph's authority to bill for treatment provided under the state workers' compensation law. Yet in spite of the abuses by Dr. Josephs which came to light at our last hearing, the

Department has taken no action to limit his participation in FECA. If the Board of Professional Medical Conduct does not revoke his license, Dr. Josephs will remain free to continue participating in FECA.

Another doctor whose activities we discussed, Dr. Richard Kones, pled guilty to over 60 counts of FECA and insurance-related mail fraud. He was recently sentenced to seven years confinement and fined $300,000. Dr. Kones also agreed to repay $500,000 to the federal government to settle a civil fraud suit. As a corollary to his plea agreement, Dr. Kones agreed to voluntarily resign all of his state medical licenses. But it would appear that the courts have no power to enforce this aspect of the agreement and in the six months since Dr. Kones entered into this agreement with the government, his record of voluntary resignations is spotty. We checked with each of the states in which Kones was licensed and found:

* In five states, the boards of medical examiners revoked his license based on his request. Dr. Kones can reapply to each state after a certain period, but his file will contain conviction records and related information.
* One state revoked the doctor's license "without prejudice".
* Dr. Kones' registration (authority to practice) has been revoked in one state, but his license has not been removed.
* Two states have not taken action against Dr. Kones.

But more importantly Dr. Kones, convicted of perhaps the largest FECA fraud scheme in the history of the federal workers' compensation program and the recipient of one of the stiffer criminal penalties meted out to a physician, has not been formally barred by DOL. The only constraint upon his ability to practice FECA is the fact that he is in a federal prison.

We must also note that there is no formal system of notification by the Department of Justice to medical societies and state boards of medicine to inform them of criminal proceedings against member physicians. As several professional groups related to us, they usually learn of such actions "by scanning the newspaper". Thus, it was only through the perseverance of the Assistant U.S. Attorney prosecuting the case that state medical boards and the American Medical Association learned of the criminal conviction of Dr. Kones.

In the case of Dr. Thomas Dent, another physician we spoke of at our last hearing, the same sense of seriousness was not reflected in the actions of those responsible for removal of his license. Dr. Dent, convicted in the U.S. District Court for the District of Columbia in June, 1981 for FECA and mail fraud, received a suspended sentence. At the time of sentencing the court, under District of Columbia law, had the power to revoke or suspend Dr. Dent's license but failed to do so. No recommendation was forthcoming from the U.S. Attorney's office--not even a recommendation for suspension. Medical licensing authorities in the District of Colombia indicated to us they were not aware of Dr. Dent's conviction, so they had not recommended license revocation to the sentencing court. We spoke to the same licensing authorities again in February, 1982 to ascertain what, if any, action had been initiated against Dr. Dent. While we were told again that no referral regarding Dr. Dent's conviction had been made by the U.S. Attorney's office, we were also informed by the very same individuals to whom we had spoken earlier, that no one recalled hearing anything of Dr. Dent or his conviction. We were assured, however, that based upon this information, proceedings against Dr. Dent could begin forthwith. To date, no further action has been taken.

Apparently, Dr. Dent's FECA conviction does not preclude him from participating in the federally-funded workers' compensation program. Barely two months after his conviction, he submitted a bill to the Labor Department for treatment rendered to a federal worker. (Exhibit 3) DOL's district office promptly paid his bill within five weeks because, as the district director explained to us, "the law says all bills have to be paid."

Ironically, the district office should not have paid this medical bill, irrespective of the treating physician's history, because the claimant switched from one physician to Dr. Dent without prior DOL approval. There was an additional administrative oversight in that two completed medical authorization forms were in the claimant's file. These administrative errors seemingly went unnoticed by DOL's district office.

The need to exclude abusive medical service providers is further shown in two other examples. We recently completed an examination of the medical services provided to a large New England Postal Service facility. The physician who provided the largest amount of medical services to postal employees injured on the job was a doctor who was formerly employed on a part-time basis by the Postal Service. The physician was hired to provide first aid and work-related injury treatment to postal workers; he was employed by the Postal Service over four years and treated hundreds of postal workers during that period.

Under DOL rules, an injured employee may be treated, for a work-related injury, by a government doctor or a private physician of the employee's own choosing. In this particular case, many postal workers would elect treatment by the postal physician in his capacity as a government doctor. The doctor would treat postal workers as a government doctor and be paid by the Postal Service for such treatment. The physician would then (as an authorized Postal Service official) execute a Department of Labor form which obligates the government to pay for private medical services--services which he would indicate were to be provided at his own private office. The doctor would then bill the Department of Labor for all treatment rendered at the postal medical facility as well as the treatment rendered at his private office. This practice continued until the doctor resigned while under investigation by the Postal Inspection Service.

This situation allowed the physician to, in effect, award a contract to himself to provide private medical services to postal workers at government expense. The physician then provided many of these services on government facilities, while he was paid to provide these same services as a government employee.

No one at the Department of Labor ever noticed that the authorizing postal official and the treating physician were one and the same person. Additionally, Postal Service personnel regulations did not specifically address this conflict of interest.

Although two years have passed since the physician resigned, the Postal Service has given little, if any, attention to tightening up its conflict of interest regulations as they apply to employee physicians. It should also be noted that we have spoken with officials at the Department of Defense, Veterans Administration and Tennessee Valley Authority. All have paid, in-house medical staffs to provide workers' compensation services to injured workers. The problem the Postal Service experienced may exist in any of these agencies.

In the meantime, the Postal Service doctor we have referred to now has a private practice, and he continues to treat a substantial number of postal employees. He is one of two physicians treating the largest percentage of injured postal workers in that area. The second physician was indicted in 1980 for distributing cocaine. This physician has not been tried as yet, and the state licensing authorities have taken no action to suspend or revoke his license.

MEDICAL COST CONTAINMENT EFFORTS

Critics of this program have long pointed to DOL's failure to issue and use medical fee guidelines as contrary to accepted industry-wide practices. The 1976 OWCP Task Force report recommended that DOL compensation offices be provided with fee schedules such as the Blue Cross/Blue Shield, private carriers, and the Veterans Administration schedules already in existence at the time. Again in 1980, in response to a DOL Inspector General's assessment of loss vulnerability, program officials promised to provide schedules of customary fees for bill payer use in determining reasonableness of charges. Although DOL gave itself a three month deadline to identify and obtain schedules for the district offices, this promise was never fulfilled.

Instead, DOL representatives told the Subcommittee last July that current procedures do not require the use of fee schedules, and district offices are not utilizing fee schedules in the routine processing of bills. The "more sophisticated" automated system, the Subcommittee was told, would include customary fee schedules as an integral part of its design and would be operational by FY 84. Meantime, district offices would continue paying medical bills according to "what is considered necessary and reasonable by OWCP."

We have recently asked every district office what criteria it uses to determine reasonableness of medical bills. All of the offices candidly admitted that no fee schedules or procedural instructions had ever been received from the national office. Almost all of the district offices could not recall a single instance when a medical bill was refused for being too high or unwarranted.

Only three out of sixteen district offices even have copies of a fee schedule to refer to in judging the reasonableness of medical fees. The fee schedule in one office is over five years old. Given the inflation rate of medical costs, its value is questionable.

NATIONAL OFFICE DIVISION OF MEDICAL SERVICES AND STANDARDS

The national office Division of Medical Services and Standards (DMSS) was first established and staffed in 1980. It was organized to provide uniform medical standards and procedures, as well as professional supervision and training for district medical personnel in order to enhance consistency in the medical functions. The need for this office had been clearly established in numerous internal and congressional studies.

By July 1981, both physicians, hired just eighteen months before to operate the DMSS, had resigned. No mention of this fact was made by the Department of Labor in its testimony before the Subcommittee last July. Instead, PSI was told that DMSS had developed and implemented a number of medical guidelines to facilitate claims development and adjudication, that it had provided technical and expert information, and that it would shortly issue directives in the complexities of adjudicating occupational disease cases.

We spoke with Dr. Wylie Slagel, the former DMSS director who is now a private practitioner in Memphis, Tennessee. Dr. Slagel attributed much of DMSS' failure to produce cohesive medical policy to those who had created the division and hired her. She told the Subcommittee staff:

> "It soon became apparent to me that my position was created as "window dressing" to dispel criticism of the Office of Workers' Compensation

> Programs...no attempt was made to introduce me to district medical directors in other parts of the country, and telephonic communication with my counterparts in district offices was not encouraged..."

Immediately before her departure, Dr. Slagel prepared a list of actions initiated, but not resolved, to respond to many medical policy needs. DMSS was limited to recommending policy changes and actions; final resolution of pending issues continued to be in the jurisdiction of federal compensation program managers.

Of the numerous proposals and draft guidelines submitted by Dr. Slagel, all of the substantive issues have yet to be resolved by the Department. Policy to be enacted covers such topics as: the conditions likely to require vocational rehabilitation, psychiatric examinations for depression, second opinions from consulting physicians, and handling of conflict of medical opinion in cases involving chiropractors. Dr. Slagel also recommended changes in the forms issued to treating physicians and proposed that performance standards for district medical directors be adopted. Finally, Dr. Slagel submitted an October 1980 draft pamphlet, "General Information for Physicians," to be issued so that treating physicians could better understand workers' compensation under the Federal Employees' Compensation Act.

Our check on the status of these recommendations shows not one has been adopted or implemented in the eight months since Dr. Slagel and her colleague resigned from the division. The Department of Labor advises that each project requires the involvement of a physician; no further action can be taken until a medical director is appointed.

What has prevented the Department of Labor from hiring replacement medical staff for the DMSS? Chairman Roth asked the Secretary of Labor about the DMSS staff in his August, 1981 letter to the Department. Two medical directors were authorized for that division, the Chairman was advised, and DOL was actively seeking recruitments. We inquired as to hiring progress in November, 1981 and were informed that a selection panel had been established to consider several candidates. In February, 1982 we asked the Department of Labor if we could meet with the new DMSS medical staff. No staff had been hired, we were advised, and no further action was planned because funding for the positions was unavailable. Since we questioned the validity of this explanation, in view of the fact that a selection panel had already met to review candidates, DOL officials subsequently informed us that the position was reannounced on the day after our meeting.

All of this has occurred long after a 1978 House Appropriations report stated:

> "While recruiting difficulties were cited as the main reason for not having filled more positions, the Investigative Staff sensed no feeling of urgency on the part of OWCP, about the immediate need for additional medical help...we believe that the longer the buildup of OWCP medical resources is put off, the more the program will continue to invite abuse and inefficiency."

IDENTIFICATION OF QUESTIONABLE MEDICAL PROVIDER PRACTICES

Department of Labor officials testified at our hearing last July that an automated system was being developed to identify patterns of questionable medical provider practices. Such a system was to be in effect by October 1, 1981. It would identify questionable providers based upon certain criteria which would indicate possible abuse. As of March, 1982, this automated system is not in place. In his August, 1981 response to this Subcommittee's letter, Secretary Donovan promised to develop information which would enable district offices to identify questionable providers. This information was to be disseminated by October, 1981.

Our survey of district offices indicates no office has received such guidelines or directions from the national office. More than half of the offices we spoke with receive individual reports of service frequency and charge amounts by providers; however, none of the offices received any direction from national on what steps to take to investigate and eliminate an abusive provider.

A few of the district offices we communicated with have informed us of their own initiatives to identify questionable medical provider practices. For example, in Boston, managers and claims examiners together compiled a list of 100 "suspect" physicians whose treatment earnings from federal compensation exceeded $10,000 last year. We chose one of the doctors included on Boston's "suspect" list and reviewed almost 150 claims files in which he was the treating physician. This particular physician is responsible for treating 75 percent of the federal workers injured at one major Department of Defense facility. The majority of patients, who typically suffer back ailments, are enrolled in the doctor's own treatment center where they may be subjected to such things as "dance therapy", "nutrition counseling", or "family therapy". In a few cases, the Boston office has discovered that patients were working and not reporting earnings while at the same time this doctor verified their total disability for compensation purposes to the Department. Despite the innovative activities in Boston and a few other district offices, the substantive issue continues to be unaddressed by the national office -- what actions should be taken once abusive or questionable provider practices have been identified? Not all medical practices or providers identified as questionable lend themselves to criminal investigation. In those cases where administrative action could suffice, there is a need to establish procedural guidelines to assist the district offices.

As we exhibited at our last hearing, state and federal law enforcement agencies, and the Health Care Finance Administration, are already engaged in the identification of fraudulent and abusive medical practitioners. In response to Chairman Roth's recommendation, the Labor Department informed us eight months ago that it was developing formal mechanisms to obtain information on such providers from these agencies. Yet, as far as we are able to determine, no district office has been provided with another agency's listing of fraudulent or administratively-sanctioned providers.

One regional administrator from New York tried to obtain the Health Care Finance Administration's list of suspended/excluded doctors. In an action which deserves some mention for initiative, the regional administrator wrote to the national office to request that it obtain and distribute the listing to the districts. Headquarters responded by thanking the administrator for his efforts to discourage fraud and abuse, but suggested that he write to the Department of Health and Human Services himself for the listing. (Exhibit 4)

This same regional official also obtained a listing of sanctioned physicians from the New Jersey Board of Medical Examiners. To determine whether any of the doctors on this listing are federal workers' compensation practitioners, the New York administrator wrote to the IRS to inquire if employer identification numbers (EINs) could be obtained for certain physicians. As we pointed out at our last hearing, the EIN is the key element needed for computer retrieval of medical provider data. IRS responded that EIN information is confidential and cannot be provided randomly for a listing of providers unless DOL verifies, on a case-by-case basis, that such information is needed in an ongoing criminal investigation. (Exhibit 5)

DOL's insistence that computer-stored information be retrieved by EIN, rather than by provider name or address, continues to hinder program effectiveness. Promises were made in response to an Inspector General report of 1980 that DOL would verify medical provider EINs with the IRS. PSI was also assured last year that the Department was working with IRS to match its EIN provider files to IRS' files for validation. The problem of multiple EINs used by the same provider was to be explored with IRS. Since that time the IRS has remained firm in its position that EIN information is confidential and could not be shared with DOL. Of course, abandoning the EIN as the tracking element in the program's computer, and replacing it with a verifiable number, would solve all of DOL's problems — with IRS privacy restrictions and multiple usage.

VERIFICATION OF MEDICAL SERVICES

In February 1981, the Inspector General recommended that DOL provide FECA claimants with a statement which would set forth all medical services which had been paid under their claim. Further, the statement would require the claimant to verify these services. This action would serve to alert both the claimant and the Department of Labor to any false billings by the medical service provider. At our July hearing, Department of Labor officials testified that a medical verification reporting system, newly installed, was expected to reduce the loss due to payment for services not actually performed by treating medical providers.

Upon subsequent questioning by Chairman Roth in August, 1981, the Secretary of Labor informed PSI that a program for verification of medical services was under development and would be implemented by the end of calendar 1981. As of our last status check in March, 1982, the verification of medical services program is not operational. Of its own initiative, however, the Boston district office recently began sending medical verification statements to a random sampling of claimants. Boston's experience with this program is not sufficient to be assessed.

TRAINING AND CONTROLS FOR BILL PAYING CLERKS

We previously presented evidence which showed DOL's lack of supervision over bill payment functions. We cited several examples of medical bills which were routinely stamped and paid by low grade clerks without scrutiny or verification that treatment was actually provided; thus, each clerk ultimately has the authority to disburse millions of dollars annually. In July, Department of Labor officials testified that a training course for bill paying clerks was in the design stages and would be operational by October 15, 1981.

We checked with each district office as recently as last week, and found that no such training course has been implemented. In the course of our survey, we also discovered that the number of bill paying personnel varies considerably from region to region, with some regions operating without full-time assistance and others functioning with eleven or sixteen clerks.

Furthermore, the Office of Inspector General of the Department of Labor issued a report which was highly critical of the controls over the bill payment function. Following an incident in the Washington, D.C. district office, where a bill paying clerk manipulated the system and embezzled $50,000, the Inspector General recommended improvements in the payment of bills. DOL officials responded by stating that the recommended improvements had been made. But the failure of the Department to make these improvements was recently dramatized by an incident in another district office. There, DOL officials now admit, a group of bill paying clerks succeeded in embezzling over $300,000 in FECA funds. This matter is currently the subject of a grand jury investigation.

LOW BACK PROJECT

This project was designed to test forms and procedures to expedite processing of low back injury claims to increase the return of employees to the work force, and to decrease the cost to the government of lingering low back injury cases.

Low back claims account for approximately 40 percent of the federal compensation claims received nationwide. Adjudication of these claims is complicated by the medical community's uncertainty and differing opinions on diagnosis and treatment. A DOL-contracted study of low back injury cases showed that low back claims are handled poorly. In over 40 percent of the cases, for example, the first claim was approved without a history of symptoms; almost 15 percent were approved without evidence that the claimant underwent a physical examination. Even where medical reports were present in files, documentation of causal relationship was inadequate. Therefore, DOL developed a project to monitor employees with low back injuries and to promptly refer to orthopedic consultants those who will be away from work more than 30 days.

Department representatives testified before a House committee in May, 1981 that the low back project was operating in the Washington, D.C. district office, and that the U.S. Postal Service as well as the Government Printing Office participated in the project. It was also stated that the project had been expanded to the New York and San Francisco district offices. When asked to assess the impact of the project, a Labor Department representative asserted:

> "After we started it...the claims dropped about 50 percent...I had a call from the Government Printing Office. They asked me, '...what did you do? All of a sudden there is a drop in reported injuries.' We had the same communication from the Postal Service. They noticed it immediately, that there was a drastic drop in reported injuries for back cases when we started that project."

Again in July, 1981, the Labor Department informed PSI that it was "particularly encouraged by the initial results of the lower back project...A by-product of this effort is a substantial reduction of the potential for abuse."

Initially impressed with the Department's success in monitoring back injury cases, we became somewhat skeptical that claims were reduced by 50 percent when we learned that, in an eighteen-month period, just six postal workers had been referred to consulting physicians. Our skepticism proved justified. A review of the history of the low back project, recently confirmed by DOL, shows:

- The project began in July, 1980 at the Washington, D.C. district office. Six postal workers were referred for specialist examinations within two months. But by October, 1980 the project was abandoned due to, as the Department now tells us, staffing limitations and procedural problems. The program was reinstated in the D.C. office in January, 1982.
- San Francisco did not even begin participating in the project until June, 1981, one month after DOL's testimony before the House.
- New York has never been a participant in the project.
- The Government Printing Office has never been a participating agency.

In summary, at the time testimony was presented to both the House committee and PSI, the Department's success rate in reducing back injury claims was measured by six case examples. Additionally, DOL representatives overstated the scope of the project.

It should also be noted that DOL's capacity to expand the study nationwide is, according to program officials, limited because some district offices do not yet have full-time medical directors. Similarly, DOL admits that unfilled physician positions at the national office Division of Medical Services and Standards continues to hamper expansion of medical studies such as this project.

AUTOMATION OF CLAIMS PROCESSING

DOL's attempts to improve the management and efficiency of the compensation program continue to move slowly. The program need identified as most urgent since the mid-1970s, automation, is scheduled for full implementation in FY 84 — fully five years later than Department officials first promised. In 1978, DOL testified before the House Appropriations Committee that full automation would be implemented in FY 79.

Full automation was not implemented in 1979. Instead, Labor officials appeared before the Senate Appropriations Committee in 1980 and requested $1.5 million in supplemental funds for the second phase of computerization. Finally, when they testifed before PSI last July, compensation program officials promised that automation would be complete and operational by FY 84 — a date far enough in the future that Chairman Roth remarked: "I suspect they may also think that by that time we will either be gone or the matter has been forgotten."

PROGRESS

On the positive side, there has been program innovation at the district office level. During the course of our field work we came across examples of program managers and their staffs attempting to address the complexities of claims adjudication, as well as fraud and abuse issues, independently. In Dallas, for example, claims supervisors and examiners work with bill paying clerks on teams, so that the team handles a claims file from initial processing, to adjudication, to long-term monitoring. The Boston district office, too, has developed a project which has enormous potential for cost savings: claims examiners select long-term cases, which meet certain fraud potential criteria, and then refer these cases to wage/hour investigators so that a face-to-face interview with the claimant can be conducted. Some 70-odd cases have been reviewed in the Boston region, using small expenditures of wage/hour staff, for an annual savings of several million dollars over the life of these claims.

This project has now been expanded by the national office, at one man-year per federal region of wage/hour inspector's time. In order to expand the project, Boston district personnel were asked to train district staff across the country in wage/hour investigative methods.

Mr. Chairman, we believe that our investigation has shown that the serious managerial weaknesses which exist in the operation of FECA result in costly and unnecessary payments. Many of the problems which we have identified were cited repeatedly by other internal and congressional studies as administrative deficiencies. It would appear that, unless the Department of Labor is prepared to make a serious commitment at this time to correct these problems, there is little hope of improvement.

PREPARED STATEMENT OF THOMAS F. McBRIDE

Mr. Chairman and Members of the Subcommittee:

Thank you for the opportunity to appear before you today to discuss the Federal Employees Compensation Act (FECA) program. I would like to briefly outline our concerns about the program, particularly related to claimant and medical provider fraud, what the Office of Inspector General is doing in these areas and what is taking place to insure that our corrective action recommendations are effectively implemented.

Claimant Fraud

Claimant fraud has historically been a problem in many government benefit programs and FECA is no exception. OIG efforts in identifying and investigating claimant fraud have been significantly increased in the past year. Also, we have studied the FECA claims management process to assess how well the system can detect and deter claimant fraud. A project initiated in the Atlanta Region, and subsequently expanded to a nationwide effort has identified unreported income and inadequate case file reviews as being significant problems.

The project's objectives were to identify:

- FECA long-term disability cases that should be reviewed for possible reduction or termination of benefits as a result of unreported income;

- areas of administrative and procedural deficiencies that need correction;

- possible instances of fraud for further investigation; and

- areas for possible administrative, regulatory, or legislative initiatives.

The Atlanta Project began in November 1980 and involved the participation of seven other agencies (the Veterans Administration, the Postal Inspection Service and the Departments of Navy, Air Force, Health and Human Services, Agriculture and Transportation). These agencies, plus TVA, are those with the largest number of FECA claimants.

The project involved the development of a profile of a high-risk claimant likely to have received overpayments or other unentitled benefits. This profile was run against the periodic roll of claimants in the Atlanta Region. The periodic roll consists of those claimants receiving long-term disability compensation on an automatic basis without the requirement of an individual claim for each compensation payment.

This process identified approximately 3,000 claimants who met the criteria of the profile, of whom 1,810 were identified as originally having been employed by the participating agencies. A comparison was then made of these claims with records of wages paid by private employers in the states within the region to determine whether or not income or wages had been reported to the state unemployment offices for these claimants.

The 1,810 claimant files then were reviewed individually to identify those that warranted further investigative or administrative attention to determine if the claimant had unreported income and the extent of the claimant's ability to earn wages when disability lessens (wage-earning capacity) and to assure that current medical evidence supported continuing benefits.

The project disclosed a number of administrative shortcomings in the processing and management of claims, most notably:

- Insufficient analysis of files by claims examiners as indicated by medical evidence inconsistent with the injury;

- lack of follow-up on requests for medical reports and lack of referrals for impartial medical examinations;
- inadequate efforts to detect unreported income;
- insufficient or conflicting information in files;
- inadequate investigation of injuries by employing agencies;
- inadequate follow-up by employing agencies to help control compensation costs; and
- inadequate attempts to rehabilitate and re-employ injured employees.

As a result of the initial review, approximately 135 of the 1,810 files reviewed were identified as needing additional scrutiny or investigation by the employing agency and 827 files were referred to OWCP for follow-up attention due to identified administrative discrepancies. To date, OWCP has terminated or suspended benefits to 67 claimants resulting in savings of approximately $630,000 annually. Considering that the average claimant is on the periodic rolls 16 years, the future cost avoidance to the government would be in excess of $10 million.

In light of the findings, we expanded this effort to cover the remaining 14 OWCP District Offices. The National FECA File Review Project began in September 1981, and the initial file reviews were completed in December 1981.

Prior to the actual review at each OWCP District Office, OIG and OWCP provided a 12 hour course of training in FECA to those employees from the participating agencies who were to perform the file reviews. Approximately 190 employees from seven federal agencies were provided the instruction. This was mandatory training to ensure valid recommendations and assessments as to the current condition of files reviewed. This training, coupled with actual participation in the file reviews, has helped to create a much greater awareness in the employing agencies of the magnitude of problems that exist in the FECA program.

The administrative shortcomings in the processing and management of claims that surfaced in the Atlanta Project were again found in the nationwide review. As the attached chart shows, we were able to physically review in excess of 10,000 periodic roll cases. OWCP is required to issue and receive form CA-1032 on a yearly basis for each claimant. This form requires the claimant to report all employment during the past 12 months, or since the last form was filed, to include self employment and/or periods of unemployment. Thus, it is a key document in proving intent on the part of the claimant in concealing outside employment while drawing FECA benefits. It also addresses the possibility of any change in dependents status. A total of 2,920 case files did not reflect a current form 1032.

Also reflected by the chart are 4,077 cases where the medical information in the file, or lack of medical information, was questioned by the reviewer. Clearly this is the most difficult area to assess and subject to considerable interpretation. In each case there should be medical justification (reports, exams, etc.) issued within the past 12 months for continuing the claimant on the periodic rolls. Frequently, the reviewers discovered that the files contained old medical reports, conflicting medical opinions, the need for an independent medical exam and failure by OWCP to follow-up on delinquent medical reports. The Postal Service even discovered 28 cases where it was being charged for the compensation costs when, in fact, the employees worked for other agencies.

A total of 676 files were deemed worthy of closer scrutiny and/or investigation by the employing agency. The employing agency was to review these files and advise us as to the number of investigations opened. This information is not yet available although we are aware of many cases being initiated. For example, as a result of the New York review, the Postal Inspection Service has initiated 50 criminal investigations.

To date, OIG has received notification from OWCP that they have terminated benefits or performed loss of wage-earning capacities (LWEC's) in excess of 100 cases that were reviewed during the nationwide project. For example, Dallas OWCP has terminated 10 claimants resulting in a yearly savings of $153,322. Denver OWCP has terminated 5 claimants resulting in a yearly savings of $62,855. Philadelphia OWCP (includes Washington, D.C.) reports six actions resulting in a savings of $57,746. Chicago OWCP (includes Cleveland) reports 90 actions resulting in a savings of $1,022,225.

Data from the other offices are being compiled at this time. Many hundreds of necessary corrective actions have been identified and are being acted upon. When results are obtained, a tremendous savings should be realized.

What is particularly disturbing is the obvious inability of OWCP to maintain current files. Our review disclosed that the smaller OWCP District Offices such as Denver, Seattle, Honolulu, Kansas City did a better job of handling their case load. More serious problems were found in the larger offices such as New York, San Francisco, Chicago, Cleveland, Dallas, Philadelphia and

Virtually all of the OIG's FECA cases which have resulted in successful prosecutions are those of unreported income by claimants. This type of case is easily identified, investigated and prosecuted. U.S. Attorneys are very reluctant to pursue a case when there is a dispute over the existence or extent of an injury. These cases frequently contain conflicting professional medical opinions or evaluations. Therefore, we are devoting the majority of our investigative efforts to unreported income cases. To date, OWCP has not initiated any system to routinely identify unreported income. The identification of unreported income is a compliance function that could be easily implemented and maintained.

Medical Provider Fraud

Of the current $856 million in annual FECA expenditures, approximately $119 million is expended for medical services. In light of this substantial expenditure and in light of some egregious provider fraud cases with which this Subcommittee is familiar, we have devoted increasing attention to both medical cost and medical provider issues. Medical providers have been able to defraud the system because the FECA program lacks very basic management control devices. For example, there have been instances when providers have charged claimants for treatments that were unrelated to their disability. Other schemes include: providers charging OWCP for visits that the claimants did not make; providers billing OWCP numerous times for the same treatment by using various identification numbers; and providers falsely certifying the condition of a claimant. Much of this medical provider fraud could be prevented if FECA improved verification procedures.

I am also concerned that the program, on its own, has not taken more initiative to identify and to track physicians/practitioners, providers and other suppliers of health care services who have been suspended, debarred, excluded or terminated from participation in Government funded medical and benefit programs, such as Medicare and Medicaid. After this subcommittee's hearings last summer, a list of debarred physicians, which had been developed by HHS's Health Care Financing Administration was provided by us to ESA. In December 1981, ESA started manually matching the list against the provider file for the Chicago District Office, the Washington, D.C. District Office #25 and the Boston Office.

The OIG has made other efforts to identify source information concerning problem providers. As a result of our review of the Longshore and Harbor Workers' Compensation program, we established contact with the Federation of State Medical Boards, who provided us with a list of doctors who had their licenses revoked. We met recently with the ESA who agreed to use the Federation's list as one screening device to identify questionable providers. Also, under the auspices of the President's Council on Integrity and Efficiency, a Health Provider Fraud Initiative has been developed by HHS. As part of that project, HHS has made contact with the Insurance Crime Prevention Institute; information received by HHS will be shared with other Federal agencies.

I would like to emphasize the need to establish and maintain an effective exchange of information between Federal and State agencies concerning fraudulent medical providers. I hope that ESA pursues this more aggressively in the future.

In addition to the lack of a system for the exchange of fraudulent provider information, the Department's Office of the Solicitor has historically interpreted the FECA legislation to preclude debarment of any medical provider who meets the state - established criteria for qualified physicians. As you know, I testified last July that OWCP, by regulation, should and could establish debarment procedures. While the Office of the Solicitor now agrees that such authority can be obtained through regulations, the regulations are still not out. In the interim, the Department has proposed legislation to clarify that FECA

Obviously, while it is critically important to identify those physicians who have been convicted, of even greater concern is preventing future provider fraud in FECA. This can be accomplished by a vigorous investigative effort and by improving internal controls within FECA. In August 1981, our regional Special-Agents-In-Charge were instructed to contact regional OWCP officials to identify and investigate suspicious providers. As a result, 23 cases are now under investigation. During my visits to OIG field offices, I have emphasized the importance of this effort.

Also, a number of recommendations made in past OIG studies would, if implemented, help to deter provider fraud and to contain medical costs. For example, we recommended that OWCP develop fee schedules of providers to assist OWCP's bill payment staff to determine the reasonableness of fees. OWCP recognized the limited effectiveness of their current guidelines but has stated that fee schedules should be based upon usual and customary charges developed from their actual experiences with billing data. OWCP expects that the fee schedule will be an integral part of their planned FECA ADP system, "Level II," however, this system is not expected to be operational until October 1984. OWCP has stated that there would be problems in fully implementing the fee schedule before the "Level II" system is operational. While a number of pilot projects and studies are now underway, I believe that ESA should do whatever is possible to accelerate development of the fee schedule.

I understand that FECA is considering adopting one of the recommendations made in our report on the Black Lung program. We recommended that, when reimbursements are sent to providers, claimants should also be sent copies of the bills to verify that they received services. If adopted, this should prevent some cases of provider fraud.

Other FECA-Related OIG Work

You should know that we have greatly increased our coverage of ESA. The OIG is now devoting about 30% of its audit and investigative resources to ESA programs. In the past two years, our audit and investigative staff years devoted to ESA have doubled.

I have already discussed some current FECA work; we also have other activities underway.

A large-scale OWCP computer matching project was initiated at the beginning of this fiscal year. This project is designed to identify potentially fraudulent duplicate benefit and medical payments made by the DOL's FECA and Black Lung programs and various other Federal entitlement programs.

We will be completing five matches of active FECA periodic roll recipients to compensation recipients in other Federal programs:

the Department of Labor's Black Lung rolls; TVA's active employee and retirement rolls; OPM's active employee and retirement rolls; the Supplemental Security Income rolls; and the VA's retirement disability compensation rolls.

These matches have been designed to identify individuals improperly receiving dual compensation and/or retirement benefits from multiple Federal programs. For example, an individual receiving disability retirement payments from OPM or TVA should not be collecting any benefits from FECA. In these cases, simple verification that both payments are actually being made will result in action to terminate payments and criminal investigations, where warranted.

Other compensation matches involve programs where some overlap with FECA is permitted by existing legislation. These will require substantial verification follow-up to determine the exact nature of the dual benefit. For example, an individual could legitimately be receiving VA disability compensation and FECA if the injuries are unrelated.

FECA medical payments will be matched against those made by three other programs: the DOL Black Lung program; CHAMPUS (a DOD medical benefits program); and one state medicare program as a demonstration of potential overlap nationwide. These comparisons have been designed to identify potentially fraudulent multiple billing by claimants, providers, or both. For example, it is possible that the same bill for the same service could be submitted to all four of the programs included and that all would pay. The results of these matches will require extensive verification work. We will also be attempting to identify patterns of medical payments or billings indicative of inflated billings, billing for bogus visits, etc.

Our FECA matching activity, including verification of raw hits, had been originally planned for completion during this fiscal year. It now appears that at least a portion of the verification process will extend well into the first quarter of fiscal 1983. The level of resources and time required to comply with the extensive administrative requirements of the current OMB computer matching guidelines and a lack of available computer processing resources within the OIG have resulted in delays in the actual computer processing of data. Additionally, verification of the massive number of raw hits expected to result from these matches will place a major drain on our audit staff.

Finally, at our request, FECA completed a comparison of the periodic compensation roll and medical payment file to the Social Security Administration death file. We have a number of "raw hits." While they have been preliminarily screened to identify the most probable improper payments, verification will be required in each case. FECA has agreed to complete this verification process but because of a lack of available staff resources has been unable to provide any estimate of the time required.

Currently, we either have on-going or planned seven special impact audits concerning FECA. To highlight a few examples, one is a financial management review of the bill payment system, both manual and automated, to determine not only the adequacy of the internal controls in the system but also to determine if any fraud is occurring. In addition, we are reviewing the efforts being made by FECA with regard to Third Party Debt Collection procedures. As you are probably aware, one of the aims of the current administration and the Congress is to improve the Government's debt collection process. We believe that a large source of monies due the Federal Government is third party liabilities. A recent GAO study reviewed potential third-party liability in FECA cases in three district offices and estimated potential collection at $4.7 million. We plan to look at the overall volume of this liability and urge the Department to take necessary collection actions.

ESA's Implementation of Past OIG and GAO Recommendations

I have previously expressed my concern about OWCP's responsiveness in implementing past audit recommendations. While Deputy Under

Secretary Collyer has shown a sincere interest in this, the fact remains that the overall responsiveness by ESA is inadequate.

In my July 1981 testimony, I mentioned some of the recommendations that were made to OWCP in our study "Loss Vulnerability Assessment of FECA Benefit Payment Program Operations in Six District Offices." This study reviewed recommendations contained in a previous OIG study and expanded on that study to include other areas of potential vulnerability to loss from fraud and abuse. The overall finding was that there were significant weaknesses in FECA because of the lack of well-designed internal controls.

Following the hearings, we scheduled a review on ESA's implementation of prior OIG and GAO audit recommendations. Our review which began late last year, has identified 112 recommendations of which ESA agreed to take action on 68. For the remaining recommendations, ESA stated that either the present procedures are adequate, the problem will be eliminated/corrected by improvements in the present system, or disagreed with the recommendation.

At the same time, we initiated an audit at one of the district offices to review the adequacies of the internal controls over financial management within ESA. During the course of our audit, two embezzlements surfaced. One was discovered by a bank employee and one by a member of my audit staff. The first fraud case involved the manual payment system and the second involved the automated bill payment system. This served to demonstrate the urgency of the follow-up effort since we believe that the fraud could have been prevented, or at least identified earlier, had our earlier recommendations been implemented.

The following are some examples of recommendations made in our report on the loss vulnerability assessment of benefits payment programs operation in six district offices which we found were not being implemented during our review in this district office.

1. We had recommended that incoming checks be safeguarded to prevent checks from being stolen. ESA stated that the fiscal manual would be revised to extend controls. However, during our survey we found that checks were maintained overnight on top of desks. As a result of our follow-up, action was taken to safeguard checks.

2. We had identified an inadequate separation of duties in that the bill paying, bill keying and bill filing which should be handled by different staff members who are functionally separated. At the time of our survey, this was not being done. By not having these functions performed by different individuals, the potential for fraud increases substantially.

3. Our report recommended that the district offices should perform a supervisory review of a statistically valid sample of bills to ensure that bills are valid. ESA agreed and stated that the FECA procedure manual requires a 10 percent sample of bills paid. An interview with the district office bill payment supervisor indicated that the 10 percent sample was not being done. Had this sample been taken, it might have uncovered either of the two embezzlements mentioned earlier, or, at a minimum, the critical internal controls not being performed would have been identified

4. Our assessment of the payment process in September 1981 recommended that the manual payment vouchers (SF-1166) for supplemental payments should be verified independently to ensure that the payee is valid and the case is in payment status. At the time of our survey, there was still an inadequate review of the SF-1166 as the supervisor was signing the form prior to all entries being entered. This was changed during our audit efforts because of the fraudulent payments discovered involving the SF-1166.

5. Our report also recommended that FECA provide claimants with periodic statements of payments made to providers for services rendered to the claimant as a means of checking for discrepancies between services and payments. ESA's response to our report

stated that this will be done for a selected group of FECA claimants. Our review disclosed that this was not being performed. The reason offered was the lack of staff to perform the function.

I have pointed out to Deputy Under Secretary Collyer that ESA had given inadequate attention to implementation of our report recommendations and that we believed there was a large degree of non-compliance at the District Office level.

We agreed that ESA would conduct some immediate surveys to determine what implementation actions have been taken. These would be followed, if necessary, by field reviews performed by either ESA or the OIG.

On February 8, 1982, a memorandum was sent to all ESA Regional Administrators and National Office Program Heads informing them that the OIG is conducting a follow-up audit and that the ESA Internal Control Unit is assisting in this effort by securing status reports on ESA actions from the National Office and by requesting the Regional Administrators to verify the implementation and impact of these actions in the field. As of March 22, 1982 information related to three IG reports has been received. ESA staff are now in the process of assessing the information. The OIG will be closely examining the results of this review and, as appropriate, will elevate certain concerns for higher-level resolution in the Department or, on a selective basis, conduct on-site verification and evaluation audits.

We don't mean to imply that if all our recommendations were implemented tomorrow, that fraud and abuse would disappear. What we are saying is that inadequate implementation of audit recommendations and circumvention of internal controls is an open invitation to fraud.

This concludes my prepared statement. I would be pleased to answer questions at this time.

NATIONAL FECA PROJECT
U.S. DEPARTMENT OF LABOR
OFFICE OF INSPECTOR GENERAL

March 26, 1982

OWCP Dist. Office	No. Files Reviewed	1032 Not Current	Medical Info. Not Current	Dependency Check	File 10 As Needing Further Invest.	Rate for Loss of Wage Earn. Cap.	Other Admin. Action	No Recommend. to OWCP Made
BOSTON - 01	509	276	324	50	30	117	171	51
CHICAGO - 10 CLEVELAND - 09	553 1218	186 625	292 636	27 50	45 21	* *	243 459	* *
DALLAS - 16 NEW ORLEANS - 07	900 308	199 62	333 78	19 8	50 8	71 45	386 48	283 118
DENVER - 12	311	42	62	4	6	4	71	108
KANSAS CITY - 11	158	28	38	1	1	10	25	80
NEW YORK - 02	1853	461	417	70	*	*	117	*
PHILADELPHIA - 03 WASH., D.C. - 25 WASH., D.C. - 50	1058	444	530	120	265	61	528	96
SAN FRANCISCO - 13 HONOLULU - 15	2390 143	476 30	1136 32	42 0	164 15	213 7	628 19	961 63
SEATTLE - 14	603	91	199	27	71	129	159	206
TOTALS:	10,004	2,920	4,077	418	*676	*657	2,854	*1,966

*DATA UNAVAILABLE AT THE TIME THIS REPORT WAS PREPARED, THEREFORE, SOME TOTALS ARE INCOMPLETE.

PREPARED STATEMENT OF ROBERT B. COLLYER

Mr. Chairman and Members of the Subcommittee:

I appreciate the opportunity to appear before your Subcommittee today to discuss our efforts to improve the administration of the Federal Employees' Compensation Act (FECA) program.

While I am here to explain the specific administrative actions that we have taken to effect improvements, particularly those actions we have taken since the hearings of this Subcommittee last July, let me make clear, as I have repeatedly stated since taking office, that administrative changes alone cannot restore the credibility of the FECA program nor eliminate its inherent flaws and inequities. Legislative changes are needed to accomplish these objectives. Today, the Federal compensation system has an overly generous benefit structure which actually provides incentives to file claims for minor nondisabling injuries and to stay off the job for more time than necessary. The Administration transmitted legislation to the Congress last year to address inequities in the current law. It will be resubmitted shortly, and will include a number of items of specific interest to this Subcommittee -- such as provisions dealing specifically with medical provider fraud and abuse, fee schedules, improved information on the earnings of disability recipients, stronger penalties for fraud or misrepresentation, and more. We are indebted to you, Mr. Chairman, and to the Subcommittee and staff, for your diligence in pursuing these concerns.

Let me also emphasize my continued belief that the key reform at the administrative level is modernization of the program through the implementation of our long-range Automated Data Processing (ADP) system. The first phase--Level I--of the ADP system was fully implemented in the fall of 1981 with the installation of the automated compensation payment system in our District Offices. Level I provides the following: an automated compensation payment system; improved tracking of case location; claims adjudication status; and case workload distribution within each of our offices. Level I also provides for a bill payment and audit control system and surveillance reports.

The Level II system will structure and control the claims adjudication process to ensure that claims examiners must follow and meet prescribed evidentiary steps before a decision can be rendered. Level II also will automatically examine bills against "accept" or "reject" codes, screening bills to assure they meet criteria for accepted conditions, frequency of service, appropriateness of treatment, and reasonableness of costs.

We expect to have Level II fully implemented during FY 1984 and we believe that this Level II system fully addresses major operation and security problems. Our firm commitment to ADP modernization is reflected in the Department's FY 1983 budget submission requesting a $3.8 million increase over the pending FY 1982 budget of $14.1 million for ESA ADP development. Of the $17.9 million requested for ESA ADP development, $10 million will be expended on FECA ADP development.

While legislation and full implementation of our ADP system are the essential prerequisites of permanent reform, there are a number of actions that can be and are being taken now -- within the context of existing legislation, current ADP capabilities, and resource levels -- to prevent fraud and abuse. Even though taken in total they can have a significant impact on the program, these actions individually often appear less significant in nature, and thus have in the past often not received the priority and follow-up monitoring they deserve. To prevent this from happening in the future:

- ESA and the Office of the Inspector General (OIG) have undertaken a cooperative arrangement to monitor ESA's progress on the implementation of recommendations for improvements made by the OIG, the General Accounting Office, and Congressional committees.
- In August 1981, I established an Internal Control Unit (ICU) to coordinate anti-waste, fraud and abuse efforts with the OIG and to strengthen ESA's own ability to deal with these related problems. The ICU has full responsibility to evaluate all ESA systems, to identify irregularities and to recommend corrective actions.

The Department of Labor -- and my staff and I personally -- are committed to achieving implementation of waste, fraud and abuse protections in the day-to-day operations of the Office of Workers' Compensation Programs (OWCP). I believe our progress to date reflects that commitment, and I would now like to briefly address our actions in that regard in six distinct areas: claims processing, case management, medical support and guidance, vocational rehabilitation, training and technical assistance, and bill payment system security.

Claims Processing

- Procedures issued October 1, 1981 provide for early notification to claimants that their claims are invalid or insufficiently documented. Prior to these procedures, claims with insufficient documentation were left "open". Under our new system, ten days after receipt of an unsupported claim of traumatic injury, a notice is issued, and the claim is denied if no additional evidence is submitted within 45 days. Undocumented occupational disease cases are denied after a second warning and within 180 days after filing the claim. The results have been that in the first quarter of FY 1982, 86% of traumatic claims have been adjudicated within 45 days as compared to 63% in the first quarter of FY 1981; in the first quarter of FY 1982, 56% of occupational claims have been adjudicated in 180 days as compared to 42% in the first quarter of FY 1981. Also, in the first quarter of FY 1982, 54,000 cases were adjudicated overall, or 30% more than were received.

- Claims for low back injuries or conditions comprised almost 18% of reported injuries. In June 1981, a pilot project was established with the Postal Service in San Francisco, and another in January 1982 in Washington, D.C., to speed the return to work of such claimants. In San Francisco, claimants are contacted within 3 weeks and referred to impartial specialists if the injury is likely to exceed 30 days. In the Washington, D.C. District Office, claimants are contacted within 7 days and referred to specialists for injuries of 7 days or more. Of 509 low back injuries identified in San Francisco, 86% returned to work within 30 days. Of 50 such cases in Washington, D.C., 36% returned to work within 7 days.

Case Management

To tighten our case management, we have instituted several improvements.

- Quality control units, now in place in District Offices, have been assigned the management control functions of making representative sample quality checks of initial adjudications, continuing daily roll payments, periodic roll reviews, and bill approvals.

- All compensation payments now require the certification by a supervisory claims examiner or designated substitute. Schedule awards require certification both by supervisors and the Chief, Branch of Claims. These procedures provide greater control over payment and ensure that claimants are not placed on the long-term rolls without supervisory review.
- Periodic review of long-term disability cases have been intensified. These reviews aim at more frequent evaluation of the claimant's current medical condition--whether it has stabilized or completely recovered--to determine the current level of disability and whether or not continued compensation is warranted. For FY 1981, 52,000 cases were reviewed. As a result, 2,000 cases were adjusted downward to reflect partial earning capacity, and 2,700 cases were removed from the rolls, yielding savings of $22 million. This is up from the $17 million saved in FY 1980.
- We have expanded the use of Wage-Hour program compliance staff to investigate suspect cases. Since the program started in October 1980, 304 cases have been referred to compliance officers for investigations. A total of 199 investigations have been completed; 105 investigations are continuing. 14 cases were referred to the OIG for investigation; of these, 8 cases were found to involve potential fraud. Savings from the 185 completed investigations are estimated at $46,000 in monthly compensation.

Medical Support and Guidance

We continue our efforts to increase the quality of medical standards for processing of occupational disease cases.

- In August 1981, detailed procedures for adjudicating asbestos-related claims were distributed with instructions for obtaining adequate information from agencies, claimants and physicians. Asbestos exposure accounted for 1,719 new claims in CY 1981, and is becoming an increasing factor.
- We are increasing our ability to handle radiation-related claims by establishing a contract with the National Council on Radiation Protection. This will significantly enhance our ability to evaluate such cases.
- Examiners receive training from local medical specialists in other common disease conditions, particularly heart, low back, psychiatric and respiratory complaints. District Offices now use 65 consultants in a wide range of specialties, such as cardiology, orthopedics and neurology, to buttress the work of medical directors in the early evaluation of medical evidence.
- The results of aggressive initial case development show in these statistics: as of January 1982, we had adjudicated 364 heart cases received in Calendar Year 1981, approving 49, or 13.5%, and denying 315, or 86.5%. We adjudicated 446 cases of stress-related emotional disorder, approving 79, or 17.7%, and denying 82.3%. Of 1,215 respiratory cases adjudicated, we approved 679, or 55.9%, and denied 44.1 percent.
- I intend to establish the position of Medical Director for all ESA programs, to replace the former medical director position which was responsible only for OWC programs. Recruitment for this position will be difficult if our recent experience over the past eight months in attempting to obtain suitable applicants for the vacant OWC medical director

position is any guide. We are intensifying our efforts to attract the best candidates by advertising in a variety of publications. We hope that these efforts, combined with the broader scope of responsibilities, raised pay cap for Federal employees, and bonus payments available for medical doctors will enable us to recruit a high caliber individual for this position.

Vocational Rehabilitation

In the area of vocational rehabilitation, we have done the following:

- In FY 1981, over $7.5 million in FECA compensation costs were saved by the successful rehabilitation of 763 workers -- 450 of whom were reemployed under the Department of Labor-Postal Service Rehabilitation agreement. This represents an increase in savings of $2 million over FY 1980.
- In FY 1981, about 7,600 employees were screened for vocational rehabilitation services. About 2,214 were accepted for services.
- Since its establishment in FY 1980, some 618 workers were reemployed under the Department of Labor-Postal Service Rehabilitation agreement. The number of rehabilitated workers reemployed increased from 168 in FY 1980 to 450 in FY 1981.
- In November 1981, we initiated a pilot project in the Chicago District Office to increase the number of injured workers rehabilitated and the timeliness of services through the use of the ADP system and expanded use of private rehabilitation agencies. The evaluation of the project will be completed by August 1982.

Training and Technical Assistance

To improve quality control of the FECA claims management and adjudication process, we have carried out an extensive program of staff training and technical assistance to other Federal agencies and within the program. This has included:

- Since 1978, newly hired examiners have received comprehensive training in all aspects of claims adjudication. To date, a total of 267 new examiners have received the training, and 286 examiners have received the advanced training course.
- In Calendar Year 1981, 99 training workshops were held for 1,010 compensation specialists in approximately 50 employing agencies and their sub-units.
- During August-November 1981, training in FECA processes was provided to OIG investigators as part of their review of the periodic long-term disability rolls.
- During October 1981-March 1982, technical assistance was provided for OIG's review of existing agency regulations and procedures impinging on FECA claims, and of agencies' interrelation with OWCP.
- We have completed course development of a formal training program for bill payment clerks. The course includes a text and handouts for trainees to instruct bill pay clerks in reviewing bills for relationship to accepted condition, relation to basic medical reports, and reasonable length of treatment. Pilot sessions will be held April 6-7, 1982, in the Washington, D.C. District Office and the Branch of Special Claims.

Bill Payment and System Security

The Subcommittee has expressed concern about our ability to control bill payments without a fee schedule. A fee schedule is something we intend to do in connection with our Level II ADP system, as I shall describe in a moment, and a provision specifically providing for it has consequently been included in the Administration's FECA legislation. Let me assure you, however, that even in the absence of such a system we do have a number of significant controls on bill payment. Automated controls have resulted in the rejection and subsequent individual review of 44,900 of the 662,000 bills received in FY 1981. These included payments totalling $7.3 million. I will now discuss some of the most significant controls.

- Instructions were issued requiring bills for office visits more than 3 months after injury and visits billed in excess of $75.00 to be approved by the bill-pay supervisor. Cases in which excessive care follows a minor injury are referred to a claims examiner for review.
- Monthly bill payment surveillance reports are now sent to all District Offices. The report identifies medical providers receiving over $1,000 for the period covered or more than $500 on the average per case, and medical providers with 5 or more cases. Bills submitted by identified medical providers are subject to closer scrutiny by claims examiners and supervisors.
- We are now producing reports at the District Office level which show all transactions for one medical provider in a given time period. Previously, reports had to be requested specifically from the National Office.
- Our ADP system rejects bills paid against false names, nonexistent cases, and cases closed more than 30 days, and requires authorizing initials for bills in excess of certain dollar amounts. It also rejects any duplicate or overlapping payments,

and will shortly be modified to reject payments to a provider not entered into the system in advance.

- We now issue quarterly reports to employing agencies, listing names of claimants, and types and amounts of payments charged. Agencies can review and notify OWCP of improper or questionable benefit payments.
- We now have the computer capability to produce a report to each claimant of the services paid by OWCP, and to medical providers showing charges paid by OWCP, to enable verification that services were actually performed. Reports for payments in the 3rd quarter will be mailed to claimants in July. A small sample mailing to providers will also be issued in July.

The Subcommittee has expressed concern about two important issues--the exclusion of fraudulent medical providers and the adoption of medical fee schedules.

On March 26, 1982, Secretary Donovan advised you by letter (a copy of which is appended to statement) that the Solicitor of Labor has concluded that the Department does have authority to issue regulations which would exclude fraudulent medical service providers from participating in the FECA program. Action to develop such regulations has been initiated. As indicated in that letter, however, we continue to favor and prefer the enactment of legislation that would unequivocally grant such authority, and it is for this reason that the Administration's FECA legislation this year will include provisions similar to those in S. 1724. In the interim:

- We are continuing efforts to obtain information on medical providers excluded under various health programs. In July 1981, all District Offices were directed to contact State health and insurance agencies such as boards of medical examiners, State licensing boards, State workers' compensation boards, State medical societies, and State private insurance organizations to obtain listings of physicians who are on probation or had their licences revoked or suspended.

- In February 1982, we began receiving from the Health Care Financing Administration (HCFA) reports on medical providers excluded or suspended under Social Security Administration programs. Several District Offices have already started to match HCFA reports against these provider files.

With regard to medical fee schedules, since July 1981, we have had several meetings with public and private health organizations to discuss the possibility of adopting existing systems. This includes discussions with the Health Care Financing Administration about using Medicare policy and procedures for paying for physicians services Unlike the FECA program, HCFA does not pay bills. HCFA contracts with more than 50 intermediary contractors for bill payment services. Each intermediary is responsible for determining the reasonableness of charges based on its Medicare experience, experience with other lines of business, and, if possible, experience of other insurance carriers in the area.

Based on these discussions with HCFA and the South Carolina Medicare contractor, we have concluded that there are several severe technical problems to be solved which preclude the successful adoption of such a system much before FY 1984. First, our present ADP equipment simply does not have the physical capacity for such a system. Development of the Level II phase of our overall ADP modernization program will provide this capacity in the form of new, expanded capacity computer equipment.

Second, the software design and programming effort must include elements that are not present in fee schedule systems now in use by Medicare and other health insurance programs. Thus, we cannot directly adopt or adapt such software programs to the FECA program. For example, all medical procedures under FECA essentially have limits on duration of treatment because disability conditions are limited. This element does not similarly exist in Medicare. Also, under FECA, billed medical procedures must be matched to the accepted disability condition of the claim; such a match should be made through the computer system to assure proper payment. This requirement does not exist in Medicare. Both of these examples represent complex system design challenges. Nor do we believe that using a manual printout of a fee schedule, such as the South Carolina Medicare fee schedule, is a feasible approach. Such a manual system would seriously impact on productivity gains achieved in claims processing. It is for these and other related technical reasons that I believe adoption of medical fee schedules will require another year of developmental work.

We have, however, undertaken steps to contain medical costs. A Request for Proposal (RFP) was issued March 10, 1982 with response due by April 14, 1982 for two medical cost containment projects to be carried out in two District Offices. One project will involve single item review of medical bills; the other will involve total service review. As part of each project, the contractor will be expected to review bills for appropriateness, frequency and cost of service.

In October 1981, we began an analysis of data on several State workers' compensation mechnisms for evaluation of charges for medical procedures. Starting March 8, 1982, we applied the results of that analysis to a relative value fee schedule project in District Office 50. Some State workers' compensation programs use relative value fee schedules as a basis for determining fair and reasonable charges for medical procedures. Relative value means that a medical procedure is given a unit value which represents its relative difficulty and takes into consideration the risk, time, ability, and skill involved. To determine what is a fair and reasonable fee, the unit value for a procedure is multiplied by a predetermined conversion factor.

The results of these projects will form the basis for an effective cost-containment program.

In conclusion, I believe that the initiatives described this morning show that we are committed to increasing the efficiency of the program and to reducing the vulnerability of the FECA program to fraud and abuse. We expect to continue to work closely with the Inspector General and your Subcommittee, Mr. Chairman, in these endeavors.

Attachment

U.S. DEPARTMENT OF LABOR
SECRETARY OF LABOR
WASHINGTON, D.C.

MAR 26 1982

Honorable William V. Roth, Jr.
Chairman
Committee on Governmental Affairs
Senate Permanent Subcommittee
On Investigations
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter of February 24, 1982. I am pleased to provide you with the information you requested on the staffing resources available to the Office of Workers' Compensation Programs. You also requested information on the status of the legal review by the Solicitor of Labor of the issue of the Department's authority to exclude fraudulent medical service providers from participating in the Federal Employees' Compensation Program.

Attached are two tables that provide the staffing information you requested. Table I shows the employment levels for OWCP and its constituent programs as of July 1, 1981, and February 1, 1982; this table also shows anticipated staffing resources for FY 1982 and FY 1983 budget request. Table II addresses your inquiry concerning the comparison of personnel reductions of OWCP with reductions in other sections of the Department.

With regard to the number of positions eliminated in OWCP through furloughs and reductions-in-force (RIF), we have been able to minimize the need for such actions through careful planning and through normal attrition and turnover of employees. The figures indicate a reduction in FEC. However, the reduction was in temporary employees. The number of full-time permanent positions was held at about the same level in FY 1982 as FY 1981, and we are asking for the same level in FY 1983. While ESA had a RIF in FY 1982, no positions were abolished in FEC.

To this date, no furloughs have occurred in ESA. We have supplemental budget requests pending before Congress to prevent any long-term furloughs. If that money is appropriated, there may still be a small fund shortage before the end of FY 1982, but we hope to avoid furloughs through additional savings.

The RIF actions that have taken place within OWCP have produced the following results:

- 74 individuals were separated from the OWCP employment rolls through RIF;
- 47 of these individuals were in the Black Lung program and held term appointments which were scheduled to expire by March 31, 1982;
- 17 other Employment Standards Administration employees were reassigned into OWCP as a result of RIF actions in other component organizations;

-- 57 positions represent the net loss of positions or persons to OWCP as a result of the RIF (-74+17=57). None of the 57 positions was lost in the FEC program.

-- An additional 23 individuals within OWCP were downgraded as a result of RIF actions and were reassigned to new duties among the FEC, Black Lung and other program divisions.

These actions naturally are disruptive to the employees and to the programs' productivity. However, we have taken what I believe are the necessary actions to minimize the resultant adverse effects and the number of terminations of individuals, and yet meet our goals for reducing the costs of government.

Finally, after careful review of the underlying statute and its legislative history and research into the available legal precedents, the Solicitor has concluded that the Department does have authority under the Federal Employees' Compensation Act to issue regulations which would exclude fraudulent medical service providers from participating in the program. Such regulations would have to be carefully fashioned, and would have to comport with the basic due process requirements embodied in the Fifth Amendment, so as to withstand judicial scrutiny. While there are serious questions as to whether the Department could, by regulation, exclude medical providers for each of the reasons set forth in your letter of August 3, 1981, I am confident that the Department can draft regulations which will achieve the basic objectives of your proposal. Toward this end, I have directed the Deputy Under Secretary for Employment Standards to begin work on this project.

Nevertheless, I favor and would prefer the enactment of legislation that would unequivocally grant such authority. Our proposed legislation which will be transmitted to the Congress would accomplish this by expressly authorizing the Department to bar from program participation medical service providers who previously have engaged in fraud or abuse.

Please be assured of the Department's continued cooperation in your efforts to improve the employees' compensation programs.

Sincerely,

Raymond J. Donovan

Raymond J. Donovan

Attachments

Office of Workers' Compensation Programs

Table II. Departmental Staffing Levels FY 1981/1982 1/

	FY 1981		FY 1982		Reductions			
Agency	Employment 7/1/81	Year End Ceiling	Employment 2/1/82	FY FTE	7/1/81 to 2/1/82 Employment	Percent	'81 Ceiling to '82 FTE	Percent
ETA	3294	3183	2790	2894	504	15.3	289	9.1
LMSA	1193	1226	1091	1045	102	8.6	181	14.8
PBGC	523	458	439	458	84	16.1	0	0.0
OSHA	2761	2655	2445	2359	316	11.4	296	11.1
MSHA	3563	3546	3162	3228	401	11.2	318	8.9
BLS	2459	2506	2311	2115	148	6.0	391	15.6
Dept. Mgmt.	3769	3763	3234	3226	535	14.2	537	14.3
ESA	4916	4821	4306	4266	610	12.4	555	11.5
(OWCP)	(1746)	(1693)	(1535)	(1569)	(209)	(12.0)	(124)	(7.3)
(FECA)	(950)	(939)	(874)	(903)	(76)	(8.0)	(36)	(3.8)
TOTAL	22,478	22,158	19,778	19,591	2,700	12.0	2,567	11.6

1/ Includes permanent, temporary, and other staff.

Office of Workers' Compensation Programs

Table I. Staffing Levels FY 1981/1982
(Including permanent, temporary, and other staff)

	Fiscal Year 1981			Fiscal Year 1982		FY 83
	Employment		Authorized	Employment	Projected Employment	Budget Request
	7/1/81	9/30/81	9/30/81	2/1/82	FYE	
FECA TOTAL	950	886	939	874	903	903
Permanent	874	848	904	839	903	903
Temp., etc.	76	38	35	35	0	0
Black Lung	595	559	555	471	481	481
Longshore 1/	164	159	167	154	157	157
DCCA 2/	37	36	32	36	28	28
TOTAL	1746	1640	1693	1535	1569	1569

1/ Includes rehabilitation program.

2/ District of Columbia Compensation Act -- funds only reimbursement by District Government. May be transferred to D.C. Government in FY 83.